

**FACTORS INFLUENCING RELAPSE IN INDIVIDUALS WITH
SUBSTANCE USE DISORDERS: VIEWS OF SOCIAL WORKERS
EMPLOYED IN TREATMENT CENTRES**

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DECLARATION

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ABSTRACT

Substance abuse is a global problem which has evoked considerable concern among patients, families, clinicians, and researchers alike. Despite the various treatment strategies put in place by many countries, including South Africa, relapse remains the most noted outcome following treatment for substance use disorders (SUDs). Previous work on the causes of relapse in SUDs has failed to explore the views of social workers as treatment professionals, but focused mostly on the service user and their significant others. Hence, the goal of this study was to explore the views of social workers employed in treatment centres regarding factors that influence relapse in SUDs. Social workers as treatment professionals are usually the first point of contact with the service user before and after they relapse, which therefore makes it important to explore their views as to why service users are entangled in this vicious circle of recovery and relapse.

The study is qualitative in nature and adopted an exploratory research design. The results of the study are based on an empirical investigation conducted with 20 social workers employed in various substance abuse treatment centres in the Gauteng, Mpumalanga and Limpopo Provinces, respectively. A semi-structured interview guide was used to collect data from the participants through one-on-one and telephonic interviews. Thematic content analysis was used as a form of data analysis.

The findings of the study revealed that various factors play a role in the precipitation of relapse at the different levels of the ecological system. It was also found that there are major gaps in the SUD treatment system in South Africa, which further exacerbates the cycle of recovery and relapse. There is a need for more public treatment facilities and the application of more locally-based treatment methodologies if relapse is to be tackled head-on. Recommendations of the study include that service users be enrolled in skills development programmes as part of their treatment to allow them to lead meaningful lives in recovery. Moreover, it is also recommended that the Government allocate more funds towards SUD treatment through adding more public treatment facilities and funding of SUD treatment NGOs.

It is envisaged that the findings of the study will contribute to the development of more strategies and programmes to combat relapse as well as help in formulating and

augmenting relapse prevention and aftercare programmes best suited for the South African context. Furthermore, the wider social work practice and other professionals globally, especially those in the addictions field, could benefit from such contributions which may enhance the possibility of a substance abuse free society.

OPSOMMING

Middelmisbruik is 'n wêreldwye probleem waar die pasiënte, gesinne, klinici en navorsers aansienlike kommer ondervind. Ten spyte van die verskillende behandelingstrategieë wat deur baie lande, insluitende Suid-Afrika, in plek gestel is, is terugval in misbruik die mees bekende uitkoms na behandeling vir middelmisbruiksversteurings (MMVs). Vorige werk oor die oorsake van terugval in misbruik in MMV het misluk om die sienings van maatskaplike werkers as behandelingspersoneel te verken, maar het meestal op die diensverbruikers en hul gesinne gefokus. Die doel van hierdie studie was dus om die sienings van maatskaplike werkers in behandelingsentrums te ondersoek rakende faktore wat terugval in misbruik in MMV beïnvloed. Maatskaplike werkers as behandelingspersoneel is gewoonlik die eerste kontakpunt met die diensverbruiker voor en na hulle terugval in misbruik, wat dus sin maak om hul standpunte te verken oor waarom diensverbruikers in hierdie bese kringloop van herstel en terugval in misbruik verstriek word.

Die studie is kwalitatief van aard en 'n ondersoekende navorsingsontwerp is gebruik. Die resultate van die studie is gebaseer op 'n empiriese studie wat uitgevoer is met 20 maatskaplike werkers wat onderskeidelik in verskeie dwelmmisbruikbehandelingsentrums in Gauteng, Mpumalanga en Limpopo betrokke was. Semi-gestruktureerde onderhoude is gebruik om data van die deelnemers te versamel deur middel van een-tot-een, asook telefoniese onderhoude. Tematiese data-analise is gebruik om die data te analiseer.

Die bevindinge van die studie het aan die lig gebring dat 'n verskeidenheid faktore 'n rol speel in die bespoediging van terugval op die verskillende vlakke van die ekologiese sisteem. Dit is ook bevind dat daar groot gapings in die MMV behandelingsisteem in Suid-Afrika is wat verder die siklus van herstel en terugval beïnvloed. Daar is 'n nood vir addisionele publieke behandelingsfasiliteite en die toepassing van meer plaaslik gebaseerde behandelingsmetodologieë indien die kwessie van terugval direk aangespreek moet word. Aanbevelings van die studie sluit in dat diensverbruikers ingeskryf word vir vaardigheidsprogramme as deel van hulle behandeling om hulle in staat te stel om meer betekenisvol in herstel te leef. Dit word ook meerendeels aanbeveel dat die staat meer fondse moet toewys aan MMV

behandeling deur die byvoeging van meer publieke behandelingsfasiliteite, asook befondsing vir NGOs wat MMV behandel.

Daar word beoog dat die bevindings van die studie sal bydra tot die ontwikkeling van meer strategieë en programme om terugval in misbruik te bekamp, asook hulp te verleen in die formulering en aanvulling van terugval in misbruikvoorkoming en nasorgprogramme wat geskik is vir die Suid-Afrikaanse konteks. Verder kan die breër maatskaplikewerk-praktyk en ander professionele persone wêreldwyd, veral dié in die verslawingsveld, baat vind by sulke bydraes wat die moontlikheid van 'n misbruikvrye samelewing, kan verhoog.

DEDICATION

This thesis is dedicated to my mother, a woman without whose encouragement and unwavering support, I would not have pulled through. To her last breath, she kept track of my progress. She may not be here physically to hold my hand and tell me “well-done”, but I know in my heart that she prayed for my success. My pillar of support, my queen, my crown fixer. Continue to rest in power mom, this is to you; Rambofheni.

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 PRELIMINARY STUDY AND RATIONALE

Substance abuse is not a new phenomenon since it has become a worldwide issue ranked among the top contributors towards crime, poverty, reduced productivity, unemployment, dysfunctional family life, political instability and escalation of chronic diseases, injury and premature death (Department of Social Welfare, 1999). According to the United Nations Office on Drugs and Crime (UNODC), every year, statistics reveal that more and more people abuse drugs and substances in one way or the other with children as young as 12 years being treated for drug dependency (UNODC, 2014). The World Drug Report (UNODC, 2017) states that five percent of the global adult population used drugs at least once in 2015 and an estimated minimum of 190 000 people died prematurely from drugs. Furthermore, the World Health Organisation (WHO) pointed that the global burden of disease related to drug and alcohol use amounts to over five percent of the total burden of disease (WHO, 2010).

In Africa, Odejide (2006) posits that poverty, political instability, social unrest and refugee problems are the main contributors to the rapid increase in substance abuse. The United States Department of State Bureau for International Narcotics and Law Enforcement Affairs in its International Narcotics Control Strategy (INCS) report (2018) noted that South Africa leads the pack as the largest market for illicit drugs entering sub-Saharan Africa. The country has seen a rapid increase in drug trafficking and substance abuse since the dawn of democracy in 1994. The drug trafficking activities of various organised crime groups have rendered South Africa as one of the prominent international players in drug trafficking networks (Ramlagan, Pieltzer & Matseke, 2010). Among other things, weak border controls and an influx of people moving in and out of South Africa have opened a gateway for “Drug Lords” to move their operations into the country for easier access to the European drug market. It can be argued that when the doors opened to democracy and economic development, numerous other challenges also showed up in the country’s doorstep, including drug problems.

The scourge of substance abuse and its deleterious effects has not gone unchallenged. The control of legal drugs in South Africa is regulated and managed through numerous pieces of legislation, including the South African Drugs and Drug Trafficking Act 140 of 1992 and the Prevention of and Treatment for Substance Abuse Act 70 of 2008. Government departments, such as the Department of Social Development have a responsibility to curb substance abuse in the country. This has led to the funding of various committed Non-Governmental Organisations (NGOs) that specialise in substance abuse treatment including the National Council on Alcoholism and Drug Dependence (SANCA), which has a presence in all the nine provinces in the country. Furthermore, efforts in the country can also be noted in the establishment of authoritative bodies such as the Central Drug Authority (CDA), which has been specifically put in place to combat substance abuse. The CDA was approved by Parliament to monitor and oversee the implementation of the National Drug Master Plan (NDMP) 2013 – 2017. This was meant to minimise the demand for and the supply of substances and to reduce harm caused by substance abuse. The ultimate goal of the NDMP is to achieve a drug free South Africa (RSA, 2008).

While the foregoing attempts to prove that mechanisms have been put in place to combat substance abuse in the country, it also seems that the scourge is difficult to contain. Substance abuse is on the rise in the country and the Human Sciences Research Council's (HSRC) seminar report on Human and Social Dynamics (HSD) contends that this is because substance abuse treatment in South Africa is underdeveloped (HSRC, 2015). The South Africa Yearbook (2015/2016) revealed that there are only seven State-owned inpatient treatment facilities, three of which are in the Western Cape Province, two in Kwa-Zulu Natal, one in Mpumalanga and one in the Gauteng Province (Department of Government Communication and Information System [GCIS], 2016). The first and only treatment facility in the Limpopo Province opened on the 23rd of October 2018, bringing the number of State owned facilities to eight. The researcher has noted with great concern that there is no updated publication on the actual number of substance abuse treatment facilities in the country, especially those that are owned or funded by the State.

Non-Governmental Organisations and the private sector run the rest of the inpatient and outpatient treatment centres around the country. Provincially, the Western Cape

has the most treatment facilities, with 32 inpatient and 16 outpatient facilities, followed by Gauteng, which has 18 inpatient and 8 outpatient facilities (DSD, 2015). Perhaps the high number of facilities in these provinces is due to the high prevalence of substance abuse as reflected by the large numbers of admissions to treatment centres (South African Community Epidemiology Network on Drug Use [SACENDU], 2017a). Peltzer, Ramlagan, Johnson and Phaswana-Mafuya (2010) also add that the Western Cape and Gauteng Provinces are the most highly urbanised provinces and have the highest rate of drug abuse. Considering the upsurge of substance abuse in the country and the fact that some provinces still have only one treatment facility, with none in the Northern Cape, it is evident that a lot still has to be done in order to address the need for treatment services for people with substance use disorders (HSRC, 2015).

Substance Use Disorder (SUD) is a complex condition, a brain disease that is shown by compulsive substance use despite harmful consequences. It is progressive and usually characterised by sequences of relapse and if not treated, may lead to disability or sudden death (American Society of Addiction Medicine [ASAM], 2018; American Psychiatric Association [APA], 2013). In South Africa, across all regions data collected by SACENDU for the period between January and June 2016, the number of admissions for individuals with SUDs in treatment centres rose to 2976 compared to 2674 in the previous six-month review period. Notwithstanding, relapse rates also seem to be on the rise. As a social worker employed in the substance abuse field for instance, I also noted that a considerable number of service users who sought treatment indicated that they had accessed treatment before, which means they relapsed. Research in different provinces around the country has also shown that most individuals treated for SUDs are not first time admissions in treatment centres (Swanepoel, 2014; SACENDU, 2017a). These are the tell-tale signs of the prevalence of relapse which is the ongoing use of substances following a period of remission or abstinence (Daley & Maccarelli, 2014).

Daley, Marlatt and Douaihy (2011) argue that although some studies have demonstrated that substance abuse treatment is concomitant with major cutbacks in substance abuse, other studies have also shown that the bulk of individuals do relapse at some point following treatment. Gorski and Kelley (1999) maintain that addiction creates complications in the psychological, physical and social functioning of a person

and treatment should therefore focus on all these areas because the worse the damage in each of these areas, the greater the chance of relapse. While Moeeni, Razaghi, Ponnet, Torabi, Shafiee and Pashaei (2016) found out that two thirds of patients relapse within a year of receiving treatment, Hsu and Marlatt (2011) add that relapse is indeed a common outcome following treatment. In support of this observation, SACENDU reported that 62 percent of patients in the Northern region, Limpopo and Mpumalanga Provinces and 56 percent in the Western Cape treated for heroin had been admitted for treatment before (SACENDU, 2017c).

Relapse in SUDs can occur as a result of many factors. Perkinson (2004) holds the view that about thirty-five percent of patients who relapse do so when they are experiencing negative feelings of frustration, loneliness, anxiety, anger or depression. Research and clinical experience has further found out that the leading causes of relapse are either intrapersonal or interpersonal factors which further generate high-risk situations that may see the individual going back to using substances after maintaining a period of sobriety. Intrapersonal factors are those generated by the individual and may include negative effects such as anger, grief or depression, while interpersonal factors are the external or environmental influences such as peer pressure or interpersonal conflict (O'Connell & Bevvino, 2007; Chetty, 2011; Voskuil, 2015). It is therefore clear that, intertwined with the problem of substance abuse in South Africa, is the problem of relapse among patients treated for SUDs. Hence, this study explores the views of social workers employed in treatment centres on the factors influencing relapse in SUDs as most research has focused on the views of service users with regards to the factors influencing relapse (Voskuil, 2015; Swanepoel, 2014; Chetty, 2011).

1.2 PROBLEM STATEMENT

Relapse is a problem that has evoked considerable concern among patients, families, clinicians and researchers alike. Witkiewitz and Marlatt (2007) submit that it is the most widely noted outcome following treatment for psychological and SUDs. Daley (1989) observed that a useful conceptual approach to understanding the problem of relapse is to view it from five perspectives, namely the client, family, treatment professionals, treatment system and other community systems. Available research has largely explored the perspective of the service users and paid attention to relapse in relation

to specific substances such as alcohol and cannabis in a specific age group, especially the youth (Van Der Westhuizen & De Jager, 2009; Swanepoel, Geyer & Crafford, 2016; Van Der Westhuizen, Alpaslan & De Jager, 2011; Mudavanhu & Schenck, 2014; Setlalentoa, Ryke & Strydom, 2015). This approach has left a paucity in the findings relating to the other four perspectives. In some studies, on relapse, Chetty (2011) focused on members of the South African Police Services and alcohol abuse, while Swanepoel (2014) concentrated on the causes of relapse among the youth in the Gauteng Province. Notably, both researchers concur that there is a dearth of research about the causes of relapse within the South African context, especially from the perspective of treatment professionals. Hence, this study sought to explore the perspectives of the social workers in treatment centres about the factors influencing relapse.

The findings from this research could contribute to the development of more effective strategies to deal with relapse as well as help in formulating and augmenting relapse prevention and treatment programmes that could help to build a drug-free nation as envisaged in the National Drug Master Plan (NDMP). The wider social work practice could benefit from such contributions, specifically social work in the field of SUD treatment.

1.3 RESEARCH QUESTION

The specific research question that the study intended to answer was: What are the views of social workers employed at treatment centres on factors influencing relapse in Substance Use Disorders?

1.4 GOAL AND OBJECTIVES

The goal of the research was to develop an in-depth understanding of the views of social workers employed at treatment centres on the factors influencing relapse in SUDs. In an effort to achieve this goal, the following objectives were formulated:

- To assess factors that contribute to relapse in SUDs within an ecological perspective.
- To describe the services and intervention programmes rendered towards SUDs in treatment centres in South Africa.

- To explore the views of social workers regarding the factors influencing relapse among service users with SUDs.
- To recommend mechanisms and policy guidelines that benefit effective implementation of SUD treatment and relapse prevention among service users.

1.5 THEORETICAL POINTS OF DEPARTURE

For purposes of this study, the researcher adopted the ecological perspective, which is a way of thinking about behaviour that endeavours to embrace diverse counselling theories under a single conceptual umbrella. Carroll (1975) cited in Daley (1989) regarded addiction as a form of “ecological dysfunction” and coined the concept that all behaviour is, like relapse for instance, a function of the process of the reciprocal influence or interaction between an individual and their environment. The ecological perspective was developed and defined by Bronfenbrenner (1979) cited by Greene (2008) as a, “scientific study of the progressive, mutual accommodation, throughout the life course between an active, growing human being and his or her own environment”. The cornerstones of the ecological perspective rest on three aspects of human behaviour. Firstly, the individual responds to events in the way they perceive them, secondly, the individual is an active role player in their environment and thirdly, human behaviour must be understood as a consequence of the individual’s interaction with their environment (Cook, 2012).

Furthermore, the ecological perspective encapsulates the complex interplay between the physical, psychological, biological, social, economic, and political forces that contribute to relapse. Lewis, Dana and Blevins (2015) argue that no client can be treated effectively unless their social interactions are taken into account. People influence their social environment and are in turn influenced by their social environment. When they develop SUDs, there is a reciprocal effect on the maintenance or resolution of the problem. Effective intervention therefore occurs when all the familial, social and cultural factors that affect the individual’s social functioning are considered (Pardeck, 1996).

The ecological perspective combines empirical knowledge with personal knowledge in the assessment and treatment of client problems. It was therefore suitable to the goal of the research in that, social workers' experiences with individuals suffering from SUDs on a day to day basis provide them a wealth of personal knowledge in this field. Moreover, the empirical knowledge gained through practice better places them as treatment professionals to provide substantive views that can significantly contribute to the field of substance abuse and future research (Pardeck, 1996). The study also drew from relevant policies and legislations that are applicable to the South African context in the field of substance abuse. These include the Prevention of and Treatment for Substance Abuse Act 70 of 2008, White Paper for Social Welfare 1997, the Drugs and Drug Trafficking Act 140 of 1992, the National Drug Master Plan (2013-2017) and the Integrated Service Delivery Model (2006).

1.6 DEFINITIONS OF CONCEPTS

1.6.1 Relapse

Daley et al. (2011) maintain that relapse refers to the inability to maintain positive behavioural change over time. For the purposes of this study, relapse is defined as the continued use of substances following treatment.

1.6.2 Substances

According to the Prevention of and Treatment for Substance Abuse Act 70 of 2008, the term "substances" refers to chemical or psychoactive substances that are prone to be abused, including tobacco, alcohol, over the counter drugs and prescription drugs (RSA, 2008).

1.6.3 Substance Use Disorder (SUD)

The fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSMV) defines Substance Use Disorder as a diagnosis based on pathological patterns of behaviours related to the use of substances measured on a continuum from mild to severe (APA, 2013). For the purposes of this study, SUD is defined as the continued use of substances regardless of the physical, social and mental consequences on the user.

1.6.4 Treatment centre

A Treatment centre as described in the Prevention of and Treatment for Substance Abuse Act 70 of 2008, refers to a private or public centre registered or established for the treatment and rehabilitation of service users who abuse or are dependent on substances. Treatment centres provide 24-hour treatment in-patient service as well as out-patient service which is a holistic treatment service, excluding overnight accommodation (RSA, 2008). In this study, a treatment centre is referred to as a facility for the specialised treatment of a service user with Substance Use Disorders. The treatment can either be on an outpatient or inpatient basis.

1.6.5 Social Worker

The Social Service Professions Act, No.110 of 1978 defines a social worker as any person who holds the prescribed social work qualification, satisfies the prescribed conditions, and the South African Council for Social Service Profession (SACSSP) that s/he is a fit and proper person to be allowed to practice in the profession of social work (RSA, 1978). For the purposes of this study, a social worker is referred to as a participant who is registered with the SACSSP as a social worker and is employed at the selected treatment centre in the Northern region of South Africa.

1.7 RESEARCH METHODOLOGY

1.7.1 Research approach

A qualitative approach was employed in this research. Fouche and Delport (2011) state that the qualitative approach helps answer questions about the complex nature of a phenomena, describing and understanding it from the point of view of the participants. They add that it takes the route of describing and understanding rather than explaining and predicting human behaviour. Creswell and Poth (2018) further point that qualitative research is a way of understanding the meanings that individuals and groups attach to social and human problems. This was the preferred approach because it gave the social workers, as the participants, the platform to give their views in relation to the factors influencing relapse to SUDs.

1.7.2 Research design

An exploratory and descriptive research design was employed in this study. Exploratory research investigates the conditions in a community, how people manage in their situation, what connotations they attach to their actions and what concerns them (Engel & Schutt, 2013). Salkind (2012) emphasises that descriptive research describes the current state of a phenomenon (which is relapse in this study) and it helps to understand the current state of events. The exploratory and descriptive design helped the researcher not only to get deeper insights on relapse but also to understand the reasons why and how it happens from a social work perspective.

1.7.3 Sampling

A non-probability purposive sampling was used in this study. Strydom and Delport (2011) highlight that in purposive sampling, the researcher must carefully consider the parameters of the population and then choose the sample accordingly. In purposive sampling, each participant is selected because of the unique characteristics that are representative of the population that serve the purpose of the study. As professionals who render services to individuals with SUDs on a day to day basis, social workers were considered as suitable informants for this study (Schutt, 2018). In accordance with this, four inpatient and outpatient substance abuse treatment centres were approached. The centres were as follows; one in the Limpopo Province, one in the Mpumalanga Province and two in the Gauteng Province. The Gauteng Province has the second largest number of inpatient treatment centres after the Western Cape Province, which is why the researcher chose to include two treatment centres from the province. A total number of twenty participants were selected from the treatment centres. Mason (2010) posits that most research has found that in qualitative research, a sample of more than 20 participants often starts to show signs of information repetitiveness. In other words, the concept of data saturation starts to kick in, whereby participants start sharing more or less of the same information or experiences, hence the selection of only 20 participants in the study. Permission to conduct the study was granted by all four treatment centres and the social workers were voluntarily willing to participate in the study (Annexure A).

The following inclusion criteria was applied for the participants:

- Be registered social workers with the South African Council for Social Service Professions.
- Be employed at a substance abuse treatment centre in the Limpopo, Mpumalanga or Gauteng Provinces.
- Must have at least one-year working experience as a Social Worker in the field of substance abuse.
- Be proficient in the English language.

1.7.4 Instrument for data collection

The researcher used semi-structured interviews, with the aid of an interview guide during data collection. Semi-structured interviews are useful in gaining a detailed understanding of the participants' dogma, insights or accounts on a particular topic. Although the researcher had a set of predetermined questions in the interview guide, these were not rigid but served to guide the interview rather than dictate how the researcher interacted with participants. This gave both the participant and the researcher more flexibility to make follow-ups and give deeper insights on emerging issues of interest (Greeff, 2011). While some of the interviews were conducted on a face-to-face basis, some were conducted telephonically owing to time, distance and budget constraints. The consent forms for telephonic interviews were emailed to the participants for signing prior to the interviews. However, the researcher conducted more face-to-face interviews than telephonic interviews. With the full consent of the participants, all telephonic and face-to-face interviews were audio recorded.

1.7.5 Pilot study

A pilot study is one of the ways a researcher can use to orientate herself to the research project. It is a small study conducted on a small group from the intended research participants in order to test if the chosen procedures are valid, reliable and effective (Strydom, 2011). The semi-structured interview guide was administered on two participants who met the same criteria of inclusion but did not form part of the main study in order to determine the efficacy or shortcomings of the questions used. There were no changes made to the interview guide after the pilot study was conducted.

1.7.6 Data analysis

Qualitative data analysis is distinguishable from quantitative data analysis in that, qualitative data analysis is rather an art than a science, hinged on a process of inductive reasoning, philosophy and theorising whilst the latter is more structured, mechanical, making use of technical procedures to make inferences from empirical data (Schurink, Fouche & De Vos, 2011). In addition, qualitative data analysis entails some kind of transformation, whereby the researcher starts with a voluminous amount of data, which they process through analytical procedures into clear, understandable, perceptive, dependable, and original analysis (Gibbs, 2007). The researcher used the thematic data analysis as a form of data analysis whereby the different themes that emerged from the interview transcriptions were filtered down into sub-themes and categories. Mclellan-Lemal (2008) makes reference to two styles of transcriptions, the naturalised and denaturalised transcription. While a naturalised transcript retains all the fine points of every utterance in the audio data, a denaturalised transcript removes personal features from the conversation and focuses on the distinctive features of the language used by producing a verbatim transcript. For purposes of this study, a denaturalised style was adopted in order to focus on the meaningful information that could provide a more comprehensive picture of the context of the study (Oliver, Serovich & Mason, 2005). Similar themes were placed into same categories and then compared to existing literature before presenting the key findings of the research in a systematic and coherent manner (Schurink et al., 2011).

1.7.7 Data quality verification

Schurink et al. (2011) maintain that credibility, transferability, dependability and confirmability are four important constructs that reflect the assumptions of the qualitative paradigm more precisely. The authors further add that the information presented should be a true reflection of what was gathered. This can be done through member checking whereby some participants are given their transcripts to ensure that what is written is exactly what they said in the interview. The methods of data verification and how they were applied in the study are briefly discussed below.

1.7.7.1 Credibility

The study was conducted in such a manner that there was a match between the participants' views and the researcher's representation of results. This was done through member checking whereby some of the participants were given their transcripts in order to check if they were a true reflection of the interviews and they confirmed that it was so (Schurink et al., 2011).

1.7.7.2 Transferability

According to Schurink et al. (2011), researchers should ask themselves whether the study was conducted in such a manner that its findings can be transferred from one specific situation to another. In order to ensure transferability, the researcher interviewed participants in different provinces to strengthen the study's context and worth in other settings.

1.7.7.3 Dependability

The dependability of a qualitative research study hinges on a logical, well-documented and audited process. The research methodology employed and the process followed in the study were clearly documented in a logical, systematic and organised manner. All chapters were reviewed by the research supervisor and edited by a professional language editor to ensure dependability (Schurink et al., 2011).

1.7.7.4 Confirmability

The construct of confirmability is attained through the concept of objectivity whereby another person other than the researcher can confirm the findings of the study. The participants were allowed to express their views without any interference. The researcher provided evidence that supports the findings through direct quotes from the interviews and interpretations of the study through literature review (Schurink et al., 2011).

1.7.8 Reflexivity

Reflexivity refers to the levels of self-reflection that permit researchers to develop themselves while making sense of how they influence and form the world. Who I am as a researcher within the research context can influence research processes and

outcomes (O'Leary, 2007). As a registered social worker employed in a substance abuse treatment centre, the researcher shares a striking similarity with the research participants. The researcher acknowledges that her experiences in rendering services to clients with SUDs has resulted in personal opinions, presuppositions and intuitions regarding the factors that influence relapse to SUDs. However, the researcher set aside all prejudices and judgements in order to conduct the study in a credible and accurate manner.

1.8 ETHICAL CONSIDERATIONS

The researcher has an ethical and professional responsibility not to violate any of the participants' ethical rights. The South African Council for Social Service Professions (SACSSP) as established under the Social Service Professions Act, No.110 of 1978, binds the researcher, as a registered Social Worker to adhere to its ethical code. Therefore, the researcher took into account the following ethical steps (RSA, 1978).

1.8.1 Informed consent

The participants were informed about the purpose of the study and were given the opportunity to voluntarily participate in the study. Each participant was given their own consent form to sign (Annexure B). Participants kept a copy while the original copy was kept in a secure place by the researcher. The consent forms for the telephonic interviews were emailed to the participants for signing prior to the interviews.

1.8.2 Confidentiality

The participants' personal data, including their names and their organisations were kept confidential. This was ensured by keeping the data in a password locked computer that is only accessible to the researcher.

1.8.3 Debriefing

The research was regarded as carrying minimum risk, because no emotional content was anticipated during the interviews, but as a contingency measure, provision was made for debriefing by way of making referrals to relevant personnel, such as other social workers, psychologists or counsellors.

1.8.4 Ethical clearance

The proposal was submitted to the Departmental Ethical Screening Committee (DESC) alongside the Research Ethics Committee (REC) at the University of Stellenbosch for ethical clearance and was approved (Annexure D). Permission to conduct research in the selected treatment centres was requested and granted prior to interviews being conducted with participants (Annexure A).

1.9 LIMITATIONS OF THE STUDY

Some limitations applied to the study. Being a social worker in the employ of an SUD treatment centre, the researcher exposed herself to a certain level of bias. However, she tried as much as possible to be objective and non-directive in order to allow the participants to explore their views openly. The study was only conducted in three of the nine provinces in the country, which could limit the generalisation of its findings to the other provinces that were excluded in the study. Additional limitations were related to the participants' lack of understanding of certain concepts used in the interview guide. For instance, when asked about the level at which they rendered their services, it emerged that most participants were not familiar with the Integrated Service Delivery Model (ISDM), hence they could not clearly state at which level they offered their services. Moreover, in relation to intervention methods applied in the treatment of SUDs, participants exhibited limited knowledge as they mostly referred to only two intervention methods; CBT and the Matrix Model, to the exclusion of other intervention methods such as the 12 steps programmes and Motivational Interviewing.

1.10 PRESENTATION OF THE STUDY

The research study is presented in five chapters. **Chapter one** is the introduction and general orientation to the study, covering the context of the study, theoretical point of departure, research methodology, ethical considerations as well as definition of key concepts. **Chapter two** of the study focuses on the first objective, which is to discuss factors contributing to relapse in SUDs within an ecological perspective. **Chapter three** describes the services and intervention programmes rendered towards SUDs in treatment centres in South Africa, while **chapter four** explores the views of social workers employed in the treatment centres regarding the factors influencing relapse of service users with SUDs. The last chapter, which is **chapter five**, draws conclusions

and makes recommendations for future research based on the implications of the study findings in the field of substance abuse.

CHAPTER 2

RELAPSE IN SUBSTANCE USE DISORDERS: AN ECOLOGICAL PERSPECTIVE

2.1 INTRODUCTION

This chapter focuses on the first objective which discusses factors contributing to relapse in SUDs within an ecological perspective. Substance abuse is a global problem which poses a significant threat to the health, social and economic state of families, communities and nations alike. An estimated quarter of a billion people around the world used drugs at least once in the year 2015. Moreover, about 60 percent of the global adult population suffer from SUDs, which means that they may experience a need for treatment (UNODC, 2017). In 2009, the combined total cost of alcohol abuse to the South African economy was estimated at 10-12% of the Gross Domestic Product (GDP), while the tangible financial cost of alcohol abuse alone was estimated at R37.9 Billion (Matzopoulos, Truen, Bowman & Corrigall, 2014). Freedman (2018) adds that an estimated 13% of South Africans suffer from SUDs during their lifetime. While some studies have shown that substance abuse treatment helps to reduce substance abuse, others indicate that most individuals relapse at some point following treatment (Daley et al., 2011). Relapse is not an isolated event, it remains a major problem in the treatment of SUDs (Robbins, Everitt & Nutt, 2010). Moe (2000) suggests that, in order to gain a better understanding of relapse, it should be studied in conjunction with addiction and recovery because no matter how long an individual has been abstinent, there is always a possibility that they will relapse.

The purpose of this chapter is to discuss factors contributing to relapse in SUDs from an ecological perspective. The conceptualisation of SUD will be discussed first, followed by a discussion on the ecological perspective. The factors influencing relapse will be deliberated on from an ecological perspective, followed by the different approaches to treating SUDs and lastly, a conclusion of the chapter.

2.2 CONCEPTUALISATION OF SUBSTANCE USE DISORDERS

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies SUDs as a combination of the categories of substance abuse and substance dependence. The Diagnostic and Statistical Manual of Mental Disorders Fourth edition

Text Revision (DSM-IV-TR) defines substance abuse as the repeated use of substances to the point of clinically significant impairment but where the pattern of the abuse does not lead to addiction, withdrawal symptoms or compulsive behaviour. On the other hand, dependence is defined as the continued use of a substance regardless of the associated problems, which may include withdrawal symptoms if the consumption of the drug is stopped (American Psychiatric Association [APA], 2000). Substance abuse and substance dependence have now been combined into a single disorder measured on a continuum from mild to severe (APA, 2013).

In the DSM-IV, SUD is defined as a complex condition, a brain disease that is shown by compulsive substance use despite harmful consequences. It is progressive and usually characterised by sequences of relapse and if not treated, may lead to disability or untimely death (APA, 2013; ASAM, 2018). A diagnosis of SUD is based on a total number of eleven pathological patterns of behaviours related to the use of substances under four categories, namely, impaired control, social impairment, risky use and pharmacological criteria. The clinician or treatment professional determines how severe the SUD is, depending on how many symptoms from the eleven criteria are identified. For instance, a diagnosis of mild SUD requires 2-3 symptoms from the list of eleven over a period of twelve months while a diagnosis of severe SUD requires six or more symptoms (APA, 2013). The bundling up of substance abuse and dependence has attracted both negative and positive feedback. Some researchers and authors have criticised the DSM-5's combination of the DSM-IV categories of substance dependence and substance abuse, generally citing that it reveals an elementary understanding about the nature of all mental disorders (Frances, 2010; Gorski, 2013; Mignon, 2015). The authors further argue that the bundling up of abuse and dependence into one category predisposes individuals whose substance use is spasmodic and transitory to labels such as "addicts" when in actual fact they are not. On the other hand, some authors have supported the move, indicating that it has advanced the understanding of addiction intensely and that the distinction in itself was rather vague and a source of confusion (Lehne, 2013; Blagen, 2015; Petry, 2016).

Fisher and Harrison (2013) note that terminology in the field of substances can sometimes be very confusing. While one author may have a specific meaning for a certain term, another may use the same term in a more general sense. Hence, it is

essential to clarify the key concepts used in this study. There has been a general tendency to use the words 'SUD' and 'addiction' synonymously. Volkow, Koob and McLellan (2016) suggest that addiction and dependence are actually components of SUD, where addiction is used to refer to the most severe chronic stage of the SUD. A closer look at the ASAM's definition of addiction also proves the synonymy of these two terms. ASAM (2018) submits that addiction is a primary, protracted disease of brain reward, motivation, memory and associated circuitry. A breakdown in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations which are mirrored in the individual pathologically pursuing reward and/or relief by substance use and other behaviours. When an individual is said to be addicted; they lose the ability to consistently abstain from the substances or regulate their behaviour even when it has dire consequences on their interpersonal relationships and life in general.

Given the above definitions of addiction and SUD, the terms seem to denote the same concept, differing only in severity. For the purposes of this study, the terms 'addiction' and 'SUD' are going to be used with reference to a severe SUD whereby the individual loses the ability to carry out normal activities and responsibilities at work, school or at home. The terms 'client' and 'service user' will be used interchangeably to refer to individuals who require treatment for SUDs or addiction.

2.3 THE ECOLOGICAL PERSPECTIVE

The ecological perspective suggests that behaviour is a function of the interaction of a person and their environment. It conceptualises the environment as a multilevel set of nested configurations, namely the microsystem, the mesosystem, the exosystem and the macrosystem, highlighting the intricacies of change at these multiple levels and considering how they interconnect to shape the individual's health and behaviour (Bronfenbrenner, 2005; Manuel, Yuan, Herman, Svikis, Nichols, Palmer and Deren, 2016). For the purposes of this study, the factors contributing to relapse will be explained from an ecological perspective, describing the systems as levels within the individual's environment. The ecological perspective allows the helping professional (who is the social worker in this study) to understand the client's situation, what stresses them, what motivates them, and their view of the role of substances in their lives and the ways in which they may be using substances to cope with their life

conditions. Furthermore, the ecological approach also permits for in-depth and full assessments of the difficulties and conditions of individuals across domains, culminating in supportive and operative evidence based interventions (Courtney & Hanson, 2014).

The microsystem is the first level and is the immediate setting within which the client interacts with their environment. Relationships at the micro-level are reciprocal; the client's reaction to the environment and the people around them determine how they are treated in return (Bronfenbrenner, 2005; Parker, 2011). In the context of a recovering client, the microsystem includes their family, peers, classmates or colleagues.

The mesosystem is the set of microsystems that make up the client's development position within a certain time. It is made up of the interactions between the different parts of the microsystem. As these systems interact, they have an ancillary bearing on the developing client. If the interactions between the microsystems are sturdy and diverse, the mesosystem is likely to have a grander impact on the recovering client (Nash, Munford & O'Donoghue, 2005; Bronfenbrenner, 2005). For example, the interactions between the client's peers and family will have an impact on them, depending on whether it is a positive or negative interaction. The mesosystem may include educators and other professional service providers such as social workers in the treatment facility.

The exosystem is an extension of the mesosystem that embraces specific social structures that do not actively involve the client but impact them significantly. Any decisions made at this level affect the client but the client is not actively involved in the decision making processes (Bronfenbrenner, 2005; Visser, 2007). For instance, the exosystem would include systems such as the school, the healthcare system and the treatment facilities. The healthcare system's decision to cut the budgets for treatment of individuals with SUDs affects the recovering client but the client is personally not involved in the decision making process. On the other hand, a school's policy on substance abuse may automatically exclude the client from the education system as they may be stigmatised because of their abuse of substances. For instance, in 2013, the Department of Basic Education introduced drug testing in schools through a document called "Guide to Drug Testing in South African Schools". The document was

guided by the Care and Support for Teaching and Learning programme which is the framework for addressing barriers to education in schools (Department of Basic Education, 2013). Child (2017) noted that experts warned that drug testing in schools could actually lead children to drop out of school or actually start using harder substances than the ones they tested positive for.

The macrosystem is the superordinate level that influences the nature of interaction within all the other levels of the ecology of human development. It is the wider social, cultural, and legal context that encompasses all the other systems (Bronfenbrenner, 2005; Xu & Filler, 2008). With the client in mind, at this level, given the grim economic situation in the country, where unemployment rates are on the increase, this disposes them to poverty. The resulting stress from all this aggravates substance abuse and subsequent addiction. Even with access to treatment, maintaining sobriety in an environment where there is no employment or any means to put food on the table, any form of entertainment or skills development, makes relapse to be imminent as substance abuse becomes the only way to numb the realities of a seemingly dead future. On the other hand, stringent policies on the trafficking of illicit substances as provided for in the Drugs and Drug Trafficking Act 140 of 1992, for instance, may shrink the supply and availability of the said substances, which can indirectly help the recovering client as they may not afford the scarce substances or totally lack access to them.

In the next section, the factors influencing relapse are discussed from an ecological perspective. Each factor is discussed in relation to the level under which it falls. The rationale behind placing the factors under the different levels of the ecological system is because not all of them apply at all levels. As indicated above, the ecological perspective describes the client's environment as a multileveled system. Examples are given to illustrate how the factors fit into the different levels of the service user's ecological system.

2.4 FACTORS INFLUENCING RELAPSE FROM AN ECOLOGICAL PERSPECTIVE

Addiction is regarded as a form of "ecological dysfunction" and according to the ecological perspective, all behaviour is, like relapse for example, a function of the

process of the mutual interaction between an individual and their environment. No client can be treated effectively unless their social interactions are taken into account because people influence their social environment and are in turn influenced by their social environment. When they develop substance abuse problems, there is a reciprocal effect on the maintenance or resolution of the problem. Effective intervention therefore occurs when all the familial, social and cultural factors that affect the individual's social functioning are considered (Pardeck, 1996; Bronfenbrenner, 2005; Lewis et al., 2015).

The work of several researchers including Marlatt and Gordon (1980) as cited in Witkiewitz and Marlatt (2007) have contributed to the conceptualisation of the factors that influence relapse in SUDs. According to Marlatt and Witkiewitz (2005), factors influencing relapse vary from person to person. Connors, DiClemente, Velasquez and Donovan (2013), posit that the dynamic relapse model categorises these factors into two broad categories, namely interpersonal and intrapersonal factors. Intrapersonal factors are those associated with the individual and their interactions with their immediate environment, while interpersonal factors include the individual's interactions with their external environment and interpersonal relationships. The factors discussed below include negative emotional state, poor social support, comorbid disorders, conditioned cues or triggers, service user's motivation, low self-efficacy, positive outcome expectancies and giving in to urges and cravings. Although these factors are discussed from an ecological perspective, not all of them fit into every single level of the ecological system.

2.4.1 Negative emotional state

A negative emotional state includes circumstances in which the recovering client may experience an unpleasant mood or upsetting emotional states such as anxiety, depression, anger, frustration, boredom, depression or loneliness preceding or during the relapse process. High risk situations can also increase stress, especially when the client cannot distinguish between what they really want and what they should have. A high risk situation is any situation, experience, feeling or thought that increases the probability for an individual to engage in the same behaviour they are actually trying to change (Witkiewitz & Marlatt, 2007).

The client becomes vulnerable to relapse when they view the benefits of substance use to be more than those of abstinence and when they do not have active coping strategies (Witkiewitz & Marlatt, 2007; Daley & Maccarelli, 2014). The cognitive-behavioural model of relapse posits that the most critical prognosticator of relapse is the individual's inability to employ operative coping strategies when confronted with high-risk situations. Individuals that focus on the current moment and accept the distress that comes with cravings and negative affect may exhibit more effective and adaptive coping strategies. If the individual does not have active coping strategies, good problem solving skills, social, stress management and leisure time management skills, they are more prone to relapse. The greater the repertoire of cognitive and behavioural coping skills, the more the individual can cope without substances (Witkiewitz & Marlatt, 2007; Daley & Maccarelli, 2014).

In a qualitative investigation of relapse episodes with a sample of males with Alcohol Use Disorders (AUDs) conducted by Marlatt and Gordon (1980) as cited by Witkiewitz and Marlatt (2007), negative emotional state was found to be the sturdiest predictor of relapse with 37 percent of the sample reporting that negative affect was the principal trigger for a relapse. Positive affect has been concomitant with more positive treatment and lesser relapse rates. A heightened emotional response coupled with a lack of skills for regulating the emotion disposes the individual to relapse. Afkar, Rezvani and Sigaroudi (2017) also found that negative mood was a contributing factor to relapse as affected individuals felt that resuming substance use would help them feel good again.

At a micro-level, for instance, the client may feel frustrated or angry over the way they were assessed or treated during an intervention effort by a helping professional. If they fail to manage that anger or frustration responsibly, they may quit treatment and revert to substance use, in an effort to counter the negative emotional state, culminating into a relapse.

On a meso-level, where the different microsystems interact, the recovering client's family (microsystem) may try to keep them from their friends (microsystem) because the family feels that is where the client is more susceptible to use substances again. On the other hand, the recovering client's friends may feel that they should spend

more time together, which may lead to conflicting emotions and frustration on the part of the recovering client, thereby prompting a subsequent relapse.

2.4.2 Giving in to urges and cravings

Craving in the substance abuse field has been described as the subjective experience of a need or desire to use substances and has been proven over the years to strongly predict relapse to substance abuse. Craving is seen as an attachment to a desired experience that has previously been achieved through the transgressive behaviour, such as perceived relaxation after indulging in substance use. It has been widely cited as the chief reason for relapse in many other addictive behaviours. For instance, Budak and Thomas (2009), in their study of patients with eating disorders who went through gastric bypass surgery to assist with weight loss, found that 20 to 50 percent of them regained the weight soon after surgery. As the individual is constantly exposed to their drug or substance of choice, the end result in most cases is the action of actually indulging themselves (Anton, 1999; Budak & Thomas, 2009; Witkiewitz & Bowen, 2010). On the other hand, Witkiewitz and Marlatt (2007) argue that although craving is possibly the most widely studied concept in the study of addictions, it is also the most poorly understood. Doweiko (2006) is also of the opinion that craving is actually a poor predictor of relapse as there is a deficiency of research findings that prove a significant link between subjective craving and objective measures of relapse. However, Higley, Crane, Spadoni, Quello, Goodell and Mason (2011) argue that constant cravings may wear down the recovering client's commitment to abstinence as they constantly long for instant gratification through substance use. If the individual in recovery is insistently exposed to substances in their environment, this might lead to a relapse.

On a micro-level, urges and cravings can come through the recovering client's peers or family. For instance, if they spend more time with friends that still abuse substances, the client may feel the urge to want to abuse substances again.

On the exo-level, the client may be prone to urges due to situations beyond their control. For example, if they cannot access treatment because the healthcare system has not provided for it, even though there is a willingness to maintain sobriety, cravings

may eventually overtake the determination and the result would be continued abuse of substances (Higley et al., 2011).

2.4.3 Positive outcome expectancies

Witkiewitz and Marlatt (2007) submit that outcome expectancies are the projected effects that the client anticipates will ensue as a result of substance use. The client's expectancies may be related to the physical, psychological or behavioural effects of substance use. Studies have shown that positive outcome expectancies, such as when an individual anticipates that they will feel happy, relaxed or outgoing after using substances, are associated with poorer treatment outcomes as opposed to negative outcome expectancies whereby the individual anticipates that after they use substances they may feel sad, guilty or ashamed.

On a micro-level, if for instance, the recovering client is ill-prepared for an upcoming academic test and they anticipate that they might actually perform better after using their substance of choice, they are most likely to indulge in substance use which then constitutes a relapse.

On a meso-level, the interactions between the recovering client's microsystems come into play. If for example, the recovering client feels saddened and discouraged by their parents' lack of trust with regards to their abstinence after treatment, this might lead to the recovering client abusing substances again in an effort to try and actually reduce the feeling of inadequacy or disappointment, which may eventually lead to relapse (Campos, 2009).

2.4.4 Low self-efficacy

Self-efficacy refers to the extent to which the individual feels self-assured and proficient of performing a certain behaviour in a specific situation. Self-efficacy is a cognitive factor that is key to recovery from addiction. In order to abstain from using substances, one has to trust that they can manage difficult situations in other ways (Skewes & Gonzales, 2013). Marlatt, Bowen and Witkiewitz (2009) note that self-efficacy pertains to beliefs in one's competencies to organise and apply courses of action necessary to accomplish certain set goals. Witkiewitz and Marlatt (2007) found that clients who relapse most are those with low self-efficacy while those with high

self-efficacy are more successful in keeping abstinent. Higher levels of self-efficacy correlate with improved SUD treatment and less likelihood for relapse.

Negative interactions between the recovering client and their close family at a micro-level, could lead to low-self efficacy, leading the client exposed to renewed substance use, and an eventual relapse. For instance, if the family does not reinforce the efforts made by the recovering client towards recovery, the client might eventually feel like they are incapable of ever accomplishing sobriety, leading to continued substance use.

2.4.5 Client's motivation

Motivation is the degree to which the individual is eager to let go of problematic behaviour, in this case, substance use (Campos, 2009). The individual with SUD may either be motivated to change their behaviour or to engage in substance use. This will depend on their desired goal, if they desire to change their behaviour, they are motivated to abstain from substances, whereas if they desire to use, they are motivated to continue using substances (Witkiewitz & Marlatt, 2007). According to Gouse, Magidson, Burnhams, Remmert, Myres, Joska and Carrico (2016), when the service user is motivated, they stand a greater chance of engaging in treatment as well as achieving greater treatment outcomes as opposed to a less motivated service user.

The intimate interaction between the recovering client and their immediate environment on a micro-level can determine the direction of their motivation. For instance, a non-supportive and derogatory family system can actually lead the service user to relapse as they try to psychologically escape the unstable family environment.

On a meso-level, for instance, where the recovering client is still at school, negative interaction between their academic institution and the family (microsystems) can lead to lack of monitoring and feedback between the microsystems with regards to the client's recovery process. As a result, the client may start using substances again and may relapse without anyone noticing because of the dysfunctional interaction between the microsystems. In other words, the communication breakdown between the school and the client's family means that they do not communicate any changes in behaviour

that may be a sign of a relapse to substances. The behaviour can include not doing the required school work, sleeping in class or out rightly not attending school for days in the end.

2.4.6 Conditioned cues or triggers

Conditioned cues or triggers occur when the individual starts experiencing a strong physiological response to a certain substance as a result of pairing the substance with events, places, people, things and internal states which trigger them. The severity of the SUD influences the range and number of conditioned cues, the power of the response to the conditioned cues and the propensity to give more attention to conditioned cues associated with substance use than other components of one's surroundings. Environmental cues elevate the risk of a relapse when the recovering client comes across people, places or things associated with their previous use of substances (Daley & Maccarelli, 2014).

On a micro-level, the recovering client closely interacts with their environment more than any other level of their ecological system. There is a reciprocal influence between the recovering client and their environment which may often dispose them to being caught up in places or with people that remind them of their substance use. This may eventually lead to indulgence and a subsequent relapse. Relationships may also result in social pressure for the recovering client which can be in the form of coercion or the need to fit with peers, leading to social use of substances and subsequent relapse (Witkiewitz & Marlatt, 2007).

2.4.7 Comorbid disorders

Comorbid disorders are disorders that occur simultaneously or sequentially. For example, the service user may be diagnosed with a certain mental disorder over and above the SUD they already have, or it could be two or more SUDs. When this occurs, it adds on to the risk of relapse and dropout from treatment. For instance, clients who are diagnosed with cocaine use disorder are more at risk for alcohol use disorder. Their use of one substance predisposes them to one or more other SUD (Daley & Maccarelli, 2014). Moreover, Clark, Baxter, Aweh, O'Connell, Fisher and Barton (2015) found out that comorbid disorders play a decisive role in the cost and progression of treatment whereby patients who have addictions to alcohol and other

drugs pay higher fees for treatment than those with a single SUD. The financial implications may result in the individual quitting treatment and falling back to previous substance use, which constitutes a relapse.

If the neighbourhood (meso-level) is awash with different drugs and substances in every corner, this may defeat the recovering client's efforts of abstinence as they will have easy access to different substances and become more susceptible to relapse. In other words, the client is prone to having multiple SUDs as opposed to just one SUD, meaning that their treatment process may require more time and money, which often poses a huge challenge, given the lack of treatment facilities and funding for SUD treatment, especially in South Africa.

2.4.8 Poor social support

Social support at all levels of the recovering client's ecological system plays a critical role in determining whether they maintain sobriety or relapse. Positive social support is closely associated with long-term abstinence rates across many different SUDs (Moeeni et al., 2016). Equally, poor social support in the form of interpersonal conflict and social pressure to use substances has been closely associated with a rise in relapse rates (Witkiewitz & Marlatt, 2007; Sharma, Upadhyaya, Bansal, Nijhawan & Sharma, 2012; Appiah, Danquah, Nyarko, Ofori-Atta & Aziato, 2017; Afkar et al., 2016). For an example, a recovering client who initially got addicted to substances because they were trying to cope with some form of abuse or conflict, when faced with the same situation while in recovery, they become susceptible to relapse if they lack the necessary support from the different levels of their ecological system.

At a micro-level, the client relies on the most immediate environment (family), as the "social reserve" from which they can draw support when threatened with stressors, protecting them from the possible adverse influences of the stressful event and possible relapse (Wei, Heckman, Gay & Weeks, 2011). If the family support is poor, the client is therefore exposed to the adverse influences and may end up re-engaging in substance use, constituting a relapse.

The exo-level, is the recovering client's environment that includes the larger neighbourhood and extended family members. Social support from these respective

social systems plays a key role towards combating relapse. When the recovering client is stigmatised and treated negatively within the larger community, they may feel isolated and dejected, which may perpetuate relapse (Bronfenbrenner, 2005; Ibrahim & Kumar, 2009).

Relapse is usually a result of many factors acting together at the different levels of the ecological system (Connors, et al., 2013). A deeper understanding of the factors influencing relapse may help add insights into the treatment of SUDs and the prevention of relapse, hence the next section discusses approaches to treating SUDs.

2.5 APPROACHES TO TREATING SUDs

Treatment in SUDs refers to the delivery of specialised medical, psychiatric and psychosocial services to individuals with SUDs (Temmingh & Myers, 2012). It is aimed at helping the service user to stop compulsive drug seeking behaviour and live a healthy life of sobriety. It occurs in different settings, forms and takes different lengths of time, and should include a multidimensional plan that is based on diverse conceptualisation of the aetiology, sequence and treatment goals (Sorensen, Hettema & Larios, 2009).

Treatment for SUDs can be divided into three phases, detoxification, recovery and relapse prevention. Detoxification aims to achieve abstinence and allow the client to undergo withdrawal symptoms safely until they subside. In recovery, the main aim is to develop motivation to avoid substance use and relapse and to learn skills to do so effectively. Relapse prevention focuses on implementing long-term strategies for maintaining abstinence which includes substituting old behaviours with a new and sober lifestyle (Kober, 2014). The majority of procedures that are used in the treatment of SUDs are usually applied at individual, group or family level. They are generally practised in different settings, which include, inpatient, outpatient and day care centres (Connors et al., 2013). The three approaches to SUD treatment are discussed below.

2.5.1 Detoxification

Detoxification is a medical process that involves a graded and measured reduction in tolerance to substances with the aim to manage and minimise withdrawal symptoms. The Prevention of and Treatment for Substance Abuse Act 70 of 2008 (RSA, 2008)

defines detoxification as a “medically supervised process by which physical withdrawal from a substance is managed through administration of individually prescribed medicines by a medical practitioner in a health establishment, including a treatment centre authorised to provide such a service under the National Health Act”. The South African Addiction Medicine Society [SAAMS] (2015) further notes that detoxification is a process of the removal of the toxins from the body and is usually the first step in SUD treatment. It is not an isolated treatment, but rather a preliminary intervention process that allows the client to enter into further treatment and maintain sobriety. Miller et al. (2011) concur that detoxification in itself is not a treatment but a preparation process for the client to enter the rehabilitation process as well as maintenance through helping them to manage symptoms and minimise any harm that may result during the withdrawal process. SAAMS (2015) posits that prior to detoxification, clients should be well prepared and enthused with a detailed treatment plan in place.

Detoxification may take place either in an outpatient or inpatient facility depending on the type of substance used and the severity of the SUD. Outpatient detoxification is usually used for clients who are highly motivated and have an established support structure, such as a family. Clients with more severe withdrawal symptoms and comorbid disorders often require inpatient detoxification (SAAMS, 2015; McKay, Kranzler, Kampman, Ashare & Schnoll, 2015; National Institute on Drug Abuse [NIDA], 2018a). Hubbard (2012) adds that detoxification is necessary because for treatment to be more successful, the body must be rid of all toxins in order to reduce the withdrawal symptoms before psychosocial intervention may follow. However, SAAMS (2015) strongly advises that clients be warned about the unforeseen risks of detoxification as the withdrawal may sometimes be complicated which also means that a detailed assessment and cautiously integrated management is required. Following a successful detoxification process, the client may then begin the long journey to recovery.

2.5.2 Recovery

Recovery is an internal change process that first starts when the client with a SUD contemplates their substance use as problematic. As the client moves towards recovery, they discontinue the use of substances and begin to examine their thoughts, emotions and behaviours in relation to their substance use. They make interpersonal

and intrapersonal changes that will allow them to uphold their change over time. Recovery is a unique and peculiar process which requires change, and to implement change, one must have goals (Brooks & McHenry, 2015; Daley & Marlatt, 2005). It is a developmental process which takes place in one or more of the following areas of functioning namely, the physical, psychological, behavioural, interpersonal, family, social, spiritual, or even financial. It is a gradual effort to learn new and progressively more amalgamated skills. Throughout the process of recovery, the client commits to learn and grow in the path of sobriety, no matter how many times they fail. The client may recover from different settings such as inpatient or outpatient facility, where they may be receiving treatment and/or support to help them maintain sobriety.

Daley and Marlatt (2005) posit that during the early stages of recovery, the recovering individual may rely more on external support, but as time progresses, they begin to be more resilient and depend on themselves. Gorski (1989) as cited in Gorski (2011) divided the process of recovery into six stages; the transition, stabilisation, early recovery, middle recovery, late recovery and maintenance stages. The author notes that each stage in the recovery process has a specific goal to be tackled individually. Furthermore, in order to understand the progression of warning signs for a relapse, it is crucial to look at the dynamic interaction between relapse and recovery processes. The stages are briefly discussed as postulated by Gorski (2011) in the context of a client with a SUD.

2.5.2.1 Gorski's developmental model of recovery

- *Stage 1: Transition*

During transition, the individual recognises that they have a problem with substance use, but they think that they can still control themselves. The main goal at this stage is to recognise and accept that one is addicted. The stage ends when the individual finally acknowledges that they are not capable of control and they need to stop using substances and regain control over their lives (Gorski, 2011).

- *Stage 2: Stabilisation*

When in stabilisation, the client is now aware that they really have a problem with substances and they need to stop but they do not yet know how to do so. This is the

stage where the client learns to be comfortable with abstinence from substances and recovers from either acute or post-acute withdrawal. Their main goal at this stage is to break the addiction cycle and reclaim control of their thoughts, feelings and behaviour (Gorski, 2011).

- *Stage 3: Early recovery*

Early recovery is the time of internal change, whereby the client is contented with abstinence from substances. Their main goal is to learn to recognise and manage addictive thoughts. Once they reach early recovery, the client is no longer preoccupied with the use of substances and they start to overcome feelings of shame, guilt and remorse associated with substance abuse. The client learns to deal responsibly with any arising problems without the use of substances. This stage ends when the client is ready to begin to practise what they learnt by straightening out other areas of their lives, such as relationships or a career that was disturbed by substance use (Gorski, 2011).

- *Stage 4: Middle recovery*

During middle recovery, the client now learns to repair and balance their life. They prioritise straightening and re-evaluating their interpersonal relationships. They take deliberate steps to make changes in areas where they are not happy. The client acknowledges and takes responsibility of the pain and damage they have caused to other people. Middle recovery marks the beginning of a holistic introspection, from emotional and physical growth to spiritual growth. The stage ends when the client has a balanced and stable life (Gorski, 2011).

- *Stage 5: Late recovery*

The client at late recovery focuses on overcoming obstacles to healthy living that they may have learnt as a child before the development of addiction. A number of challenges may arise during this stage that may result in major life stressors. A number of self-defeating personality traits must be identified and be done away with. These may include the problems that the recovering client has as an adult that came as a result of growing up in a dysfunctional family, learning how to recover from the pain caused by growing up in a dysfunctional family as well as learning how to solve current problems in spite of the hindrances caused by how they grew up. Late recovery ends

when the individual has learnt to live a meaningful and contented life of sobriety (Gorski, 2011).

- *Stage 6: Maintenance*

Maintenance is a lifelong stage, to which there is no end whereby the client recognises their need for growth and development as a human being. The client recognises that they can never safely use substances and must therefore practise to keep the addictive behaviour at bay. They begin to live a quality life that allows for enjoyment, focusing on staying sober. Problems encountered at this stage are dealt with effectively in a responsible way, with little or no jeopardy to their recovery process (Gorski, 2011).

2.5.3 Relapse prevention

Relapse is defined as the recurrent resumption of drug use after detoxification and abstinence. It is one of the most challenging problems in the treatment of SUDs (DiClemente, Holmgren & Rounsaville, 2011). According to Marlatt and Donovan (2005), relapse is a formidable challenge in the treatment of all behaviour disorders, especially SUDs. This is mainly because individuals working on behaviour change are often faced with cravings, cues and thoughts regarding the very same maladaptive behaviours they are attempting to change. Connors et al. (2013) add that there are solid suggestions that relapses are not determined by a singular factor, but are instead influenced by several factors that act concurrently.

There are various models of relapse prevention that have been coined over time to help apprise clinical practice and direct future research. Although varied in their names, most relapse models have a lot in common. They all focus on the need for the individual with a SUD to cultivate new coping skills and prepare themselves to counter and manage relapse (Daley & Marlatt, 2005; Connors et al., 2013; Menon & Kandasamy, 2018). For purposes of this study, the CENAPS model, the cognitive-behavioural model and the dynamic model of relapse are discussed. These models have played a significant role in hypothesising and studying the dynamic characteristics of the relapse process as well as prevention of relapse. The aim of the study is to investigate the factors influencing relapse in SUDs and these models have contributed immensely in conceptualising the taxonomy of factors that precipitate

relapse. Over the years, they have been the focus of substantial research and have informed various treatment approaches in the field of substances (Larimer, Palmer & Marlatt, 1999). The models of relapse are hereby discussed below.

2.5.3.1 The Centre for Applied Sciences (CENAPS) model

Gorski's CENAPS model is a model of relapse prevention that has gained popularity over the years. It was developed by Terrence Gorski in the early 1970s. Guided by the disease model of addiction, the CENAPS model prescribes to the view that SUD is a biopsychosocial disease which affects the biological, physical, psychological, and social functioning of the individual (Fisher & Harrison, 2013). It mainly focuses on helping recovering clients to identify signs of relapse from an early stage so that they may act accordingly and interrupt the progression of relapse. Within the CENAPS model, clients are categorised into two; those who are recovery prone and those who are relapse prone. Those who are relapse prone are further subdivided as either motivated or unmotivated, and those who are unmotivated are reluctant to make lifestyle changes as opposed to those who are motivated. Treatment is therefore given according to which category the client falls into (Coombs & Howatt, 2005; Fisher & Roget, 2009). Furthermore, the CENAPS model differentiates between service users who have attained four primary goals and those who have not.

The first goal is the recognition that SUD is a biopsychosocial disease, secondly, the recognition of the need to completely abstain from all mind-altering drugs, thirdly, the development and practice of a continuous recovery programme to sustain abstinence, and fourthly, the diagnosis and treatment of any co-occurring conditions that can impede recovery. The CENAPS model employs various techniques in relapse prevention that promote self-awareness, education about relapse, identification of signs of relapse, strategies to manage those signs as well as the involvement of others such as family members for support (Fisher & Harrison, 2013).

2.5.3.2 The cognitive-behavioural model of relapse

The cognitive-behavioural model of relapse was first introduced by Marlatt and Gordon (1985). Its primary basis is the identification of high-risk situations and how the individual reacts in a high-risk situation (Witkiewitz & Marlatt, 2011). The cognitive-behavioural model of relapse was first developed as the basis for intervention among

individuals with alcohol use disorders, but it is now largely applied to different SUDs. The model focuses on the high-risk situations that dispose the individual to substance use as well as the individual's reaction in those situations. The cognitive-behavioural model of relapse combines behavioural skills training with cognitive interventions designed to prevent or limit occurrences of relapse (Marlatt & Witkiewitz, 2005). High risk situations predispose the individual to the risk of relapse. The model proposes that if an individual is faced with a high risk situation, and they lack effective coping strategies, they will experience a decrease in self-efficacy, and if they have positive outcome expectancies with regards to the use of their substance of choice, there is a greater likelihood for a relapse. On the other hand, individuals with effective coping strategies experience an increase in self-efficacy, meaning that they have confidence in their ability to exercise self-control, and are less likely to relapse.

2.5.3.3 The dynamic model of relapse

The dynamic model of relapse was proposed by Witkiewitz and Marlatt (2004) and builds on to the cognitive-behavioural model of relapse. Instead of viewing the determinants of relapse in a simple linear format as postulated by Marlatt and Gordon (1985), Witkiewitz and Marlatt (2004) suggest that these factors are multidimensional and dynamic. They argue that the process of relapse is of a complex and dynamic nature (Marlatt & Witkiewitz, 2005). The dynamic model of relapse is unique due to its ability to integrate diverse patterns of distal and proximal factors of relapse and its acceptance of the contribution of these factors in the precipitation of relapse. Distal factors include personality, genetic or familial risk factors, drug sensitivity and physical withdrawal profiles while proximal factors include urges or cravings, mood, or temporary changes in outcome expectancies, self-efficacy, or motivation. For instance, coping skills influence substance use behaviour and in turn, substance use behaviour influences coping. In agreement with the old model, the reconceptualised model also emphasises that if an individual is faced with a high risk situation, for which they lack effective coping strategies, they are highly likely to experience a decrease in self-efficacy, and if they have positive outcome expectancies with regards to the use of their substance of choice, there is a greater likelihood for a relapse.

Although the old model by Marlatt and Gordon (1985) has received wide theoretical and practical support over the years (Larimer et al., 1999), Marlatt and Witkiewitz

(2005) note that it lacked dynamism and multidimensionality in that it presented relapse risks in a simple and linear format. Menon and Kandasamy (2018) posit that this is what differentiates the old from the new model. For example, the old model suggests that the use of an effective coping strategy guarantees an increase in self-efficacy, which in actual terms may not always be the case according to the dynamic model. Marlatt and Witkiewitz (2005) argue that the dynamic model of relapse is more practical in that it takes into account the complexity and dynamic nature of the relapse process. It acknowledges the fact that the individual with a SUD is constantly faced with the challenge of striking a balance between multiple cues and possible consequences.

2.6 CONCLUSION

The chapter explored the factors that influence relapse from an ecological perspective. Conceptualising the factors influencing relapse from an ecological perspective helped shed light and make easy the understanding that relapse is not an isolated issue that emanates from the individual alone. Various factors from the different levels of the ecological system also play a significant part in aggravating relapse. There is a gap in literature on accurate statistics on relapse rates, especially in South Africa. This could be due to the fact that most statistics rely mostly on submissions by SACENDU, which paints a picture of the substance abuse trends based on admissions to selected treatment centres around the country.

The following chapter discusses the services and treatment programmes rendered for SUDs in treatment centres within the South African context. As much as substance abuse and its deleterious effects continues to be a global problem, for the purpose of this study, it is also important to focus on the services rendered in the local context. This will assist in exploring what is working and also establishing the existing gaps for future research in the area of addiction.

CHAPTER 3

SERVICES AND INTERVENTION PROGRAMMES RENDERED TOWARDS SUDs IN TREATMENT CENTRES IN SOUTH AFRICA

3.1 INTRODUCTION

This chapter flows from the second objective which seeks to describe the services and treatment programmes for SUDs as rendered in the South African treatment centres. Substance abuse treatment has evolved over the years, moving between formal and informal methodologies in pursuit of what is effective and what is not. Connors et al. (2013) define treatment as an application of established methods to ascertain and alter patterns of behaviour that are maladaptive, destructive, and not good for the health in order to restore fitting levels of physical, psychological or social functioning.

Treatments for SUDs are varied and complex as is apposite, given the heterogenous and multifarious nature of the disorders that they treat. The most common outcome in the treatment of SUDs is relapse. Although some individuals successfully remain abstinent, the majority of them usually return to substance use within a year, even with the best of treatments (Witkiewitz & Marlatt, 2007; Daley et al., 2011; Hsu & Marlatt, 2011). Rasmussen (2000) notes that addiction treatment is a collective process involving the treatment professionals and the client.

This chapter provides an overview of substance abuse, followed by a discussion on the policies and legislations applicable to substance abuse in South Africa. The nature of the treatment settings will be reviewed, followed by a discussion on the levels of service delivery in the context of substance abuse treatment in South Africa based on the Integrated Service Delivery model [ISDM] (DSD, 2006). Lastly, interventions for SUD treatment are briefly discussed followed by the conclusion of the Chapter.

3.2 AN OVERVIEW OF SUBSTANCE ABUSE IN SOUTH AFRICA

Substance abuse is a worldwide issue with adverse effects that extend far beyond the individual, affecting significant others and the larger society (Freeman, Pretzer, Fleming & Simon, 2004). Five percent of the global adult population used drugs at least once in 2015 and an estimated minimum of 190 000 people died prematurely

from drugs. Furthermore, in 2013, illicit drug use was estimated to be accountable for over 39 600 road traffic deaths worldwide (WHO, 2016; UNODC, 2017).

In South Africa, substance abuse is twice the global average and is still increasing. Frequently abused drugs are alcohol, cannabis, tobacco, and glue. An estimated two million people in South Africa are classified as problem drinkers. Furthermore, substance abuse costs the country more than 130 billion in socio-economic costs (DSD, 2011a). South Africans Against Drunk Driving (SADD) submitted that South Africa has the worst road traffic injury statistics in the world with an estimated 1714 people dying on the roads due to drunken driving during the 2016/2017 festive season (SADD, 2017). Moreover, the South African HIV Clinicians Society (SAHIVSOC) reported that an estimated 15 percent of the South African population are problem drug users, with the majority of offenders indicating substance abuse being males. Children under the age of 18 years constitute 21 percent of offenders indicating substance abuse while adults make up 79 percent (SAHIVSOC, 2016). Given the above statistics, it is irrefutable that substance abuse is on the increase, both globally and locally. This further means that treatment demands for SUDs are also escalating (Peltzer et al., 2010; Swanepoel, 2014). The South African Community Epidemiology Network on Drug Use (SACENDU) concurs when they report that there has been a notable increase in the number of persons admitted to specialist treatment centres around the country (SACENDU, 2017a).

There is dearth of statistics with regards to substance abuse in South Africa as most statistics rely only on submissions from the SACENDU, which collects admission data from various treatment centres across the country and uses their findings to paint a picture of the current trends of substance abuse. However, despite the shortage in statistics, it is significant to provide a brief overview of substance abuse in the Limpopo, Mpumalanga and Gauteng Provinces since the study was carried out in these areas.

Statistics from SACENDU show that the main substances abused in Mpumalanga and Limpopo Provinces are cannabis followed by heroin and alcohol, which together make up 89 percent of the total admissions in these provinces. On the other hand, cannabis still remains the substance of choice in Gauteng, followed by alcohol, heroine, CAT, methamphetamine and Nyaope respectively (SACENDU, 2017b). Relapse in these

provinces is also rife. Sixty-two percent of patients in the Northern region, which is made up of Limpopo and Mpumalanga Provinces, has been admitted for treatment before, while in Gauteng, re-admissions constitute 22 percent of the total admissions. Reports based on admissions to treatment centres also show that the majority of heroin and Nyaope users are black Africans, with a bigger proportion being younger than 20 years of age, especially in the Northern and Gauteng regions of South Africa (SACENDU, 2017c). Pretorius, Van den Berg and Louw (2003) suggest that this is due to this age group's vulnerability to peer pressure and a need to belong and fit in, while the UNODC (2004) adds that young people have a tendency to want to take risks and explore the unknown. Grant (2014) notes that in Gauteng, Limpopo and Mpumalanga, heroin and marijuana are the most abused substances, seeing an increase in treatment admissions from 22 percent to 29 percent between July 2012 and June 2013. Mokwena (2016) observes that this is due to marijuana being easily accessible and affordable, while Ghosh (2013) found out that young people are often entangled in the web of hopelessness due to poverty and joblessness, which makes substance abuse their only escape route. Ondieki and Mokua (2012), further suggest that the high usage of marijuana is due to its effect on sensory distortion which makes young people feel as if they are experiencing something extraordinary. Given the above, it is clear that the worst casualties in the blight of substance abuse in the country are young black males.

3.3 LEGISLATION AND POLICIES APPLICABLE TO SUBSTANCE ABUSE IN SOUTH AFRICA

There are several pieces of legislation and policies that guide and inform the field of substances in South Africa. Some of them are discussed below.

3.3.1 The Drugs and Drug Trafficking Act 140 of 1992

The Drugs and Drug Trafficking Act 140 of 1992 is a legislation that manages and controls drugs and substances in South Africa. The country has seen a rapid increase in drug trafficking since the dawn of democracy in 1994. South Africa is rated as one of the largest markets for illicit drugs entering southern Africa. The Act is therefore one of the key instruments that can be used to 'freeze' these drug routes and help fight the plague of substance abuse in our country (RSA, 1992; UNODC, 2002; Ramlagan et

al., 2010). Among many things, the Act primarily seeks to address the problem of substance abuse and trafficking in the South African society. It specifically states that it is illegal to supply any substances to anyone with the full knowledge or suspicion that the individual will use the substances to manufacture illegal substances. Furthermore, under the Act, people are obligated to report any suspicious activities pertaining to the use or possession of any drugs that contravene the provisions of the Act (RSA, 1992).

Under the Drugs and Drug Trafficking Act, any person who converts the proceeds gained from illegal drug dealings or trafficking is liable to prosecution. Anyone who is found guilty of dealing in any dangerous dependence-producing substances can be sentenced to an imprisonment of 5 to 25 years (RSA, 1992). In 2014, Schedule 1 and 2 of the Drugs and Drug Trafficking 140 of 1992 were amended by criminalising drugs such as Nyaope, which meant that anyone found in possession and dealing in Nyaope would be lawfully prosecuted. The main aim in the criminalisation of Nyaope was to try and discourage people from abusing the drug which has gained popularity and wreaked havoc all over the country (Department of Justice and Constitutional Development, 2014). As much as this amendment would help in realising a substance free country, it has not gone without criticism. Monyakane (2016) argues that the amendment has really gone too far especially where Nyaope is concerned. The author observes that the problem of Nyaope is more of a health issue than it is a criminal justice issue, which means that most Nyaope users with serious health problems would find themselves imprisoned instead of being offered other alternatives, such as treatment. The imprisonment of Nyaope users further aggravates the problem of substance abuse as most incarcerated individuals have little or no access to substance abuse treatment. NIDA (2018c) suggests that if the criminal justice system combines prison and community-based treatment for SUDs, there can be a significant decline in repeated drug use as well as relapse rates.

Until recently, dagga was also listed in Part III of Schedule 2 of the Drugs and Drug Trafficking 140 of 1992 as an “undesirable dependence-producing substance” (RSA, 1992). However, this has now changed. Child (2018) reported that in September of 2018, the Constitutional Court of South Africa ruled that it was no longer illegal for an adult to consume dagga in private or grow it for private consumption. The

Constitutional Court gave the Parliament 24 months from the time of the ruling to make amendments to the Drugs Act and the Medicines Act to line up with its judgement. Before the Constitutional Court judgement, according to the Drugs and Drug Trafficking Act 140 of 1992, it was illegal to deal in, possess or sell dagga in South Africa (RSA, 1992).

The legalisation of dagga is not a new phenomenon, as far back as 1996, the State of California in the United States of America decriminalised it for medicinal purposes (Minnaar, 2015). Over the years, support for the decriminalisation of dagga has grown all over the world. Different reasons have been brought forth on the benefits of decriminalising dagga, including that it would result in taxation gains and additional revenues through proper regulation, reducing its hazardous effects on health through quality control, job creation and ancillary products through industrial beneficiation. Furthermore, in South Africa, it has been argued that decriminalising dagga would actually assist in doing away with the illicit market (Minnaar, 2015). Although the decriminalisation of dagga in South Africa seems like a sweeping victory for those who advocated for it over the years, Smit (2018) notes that the implications are far-reaching than foreseen. There are a lot of blurred lines with regards to issues such as the 'where, how and when' it would be legal to use dagga. In other words, what really constitutes a 'private space?'

3.3.2 The Prevention of and Treatment for Substance Abuse Act 70 of 2008

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 also informs the rendering of social services within the substances field in South Africa. The Act, provides for the involuntary treatment of clients with substance use disorders who pose a danger to themselves, their immediate environment or pose a major public health risk, cause harm to their welfare or the welfare of their significant others or engage in criminal activities to feed their substance use habit (RSA, 2008; SAAMS, 2015). The Act also provides for an inclusive national response for the combating of the scourge of substance abuse as well as demand and harm reduction of substance abuse through the establishment of treatment centres and different programmes which include prevention, early intervention, treatment, reintegration and after care. Through providing for reintegration and aftercare services, the Act specifically caters for relapse prevention and sobriety maintenance. It stipulates that, the service user should be

allowed to share long-term sobriety experiences and be empowered to abstain from substances. Furthermore, under the Prevention of and Treatment for Substance Abuse Act 70 of 2008, the establishment of treatment centres for the rehabilitation of service users with SUDs is also outlined. According to the Act, an outpatient treatment centre is one that provides non-residential service to persons who abuse substances and to persons affected by substance abuse. On the other hand, an inpatient treatment centre provides services while the service user resides within the treatment centre. Both inpatient and outpatient facilities are required to be registered and must comply with recommended regulations as set by the Director-General, who is also empowered to deregister them if they do not comply with the recommended regulations (RSA, 2008). For the purposes of this study, inpatient and outpatient treatment facilities are discussed in detail in the next chapter.

3.3.3 The National Drug Master Plan (NDMP) 2013-2017

The National Drug Master Plan (NDMP) 2013–2017 was formulated by the Central Drug Authority (CDA) in terms of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (RSA, 2008). The NDMP stipulates the roles and contributions of different government departments in combating substance abuse. The CDA is the authoritative body that was approved by Parliament to monitor and oversee the implementation of the NDMP. In formulating the NDMP, the CDA proposed three integrated strategies that would help solve the problem of substance abuse in the country. The strategies are aimed at minimising the demand for and the supply of substances and to reduce harm caused by substance abuse. Harm reduction speaks to the development of policies and programmes that focus on decreasing the harm caused by substances in different aspects of society while supply reduction is focused on stopping the production and distribution of illicit drugs through law enforcement strategies. Demand reduction focuses on policies and programmes that aim to reduce the need for substances through prevention which may include educating people about the adverse effects of substance abuse.

The ultimate goal of the NDMP is to achieve a drug free South Africa through concerted efforts of the different stakeholders such as national and provincial government departments and Local Drug Addiction Committees [LDACs] (RSA, 2008). The LDACs' main mandate is to effect the plans and strategies of the NDMP.

The committees also compile an action plan that is matched with the specific needs of the particular municipality or area in order to combat substance abuse in collaboration with provincial and local government. For the plans and strategies of the NDMP to be effective, they should be closely monitored and evaluated on a regular basis, hence the Department of Social Development (DSD) emphasises the need for effective monitoring and evaluation which is necessary for assessing the success of Social Welfare services and informing future planning and decision making (DSD, 2011a).

Although the NDMP was specifically put in place to combat substance abuse, its functionality and effectiveness has been marred by several challenges. For instance, there is very little, if any partnership or inter-sectoral collaboration between the State, civil society and the private sector (SACENDU, 2015). On the other hand, there has been a lack of monitoring and evaluation in the implementation of the NDMP (DSD, 2013). Myers and Parry (2005) noted that there is an increase in substance abuse treatment, but there is still a limited accessibility of existing services, particularly for black South Africans. The authors further add that private Non-Profit Organisations (NPOs) and outpatient facilities serve the highest proportion of black clients compared to State-owned facilities and profit making organisations. Dos Santos, Rataemane, Fourie and Trathen (2010) suggest that the inaccessibility of services is also exacerbated by the closure of several treatment centres and the cutting down of subsidies for organisations such as the South African National Council on Alcoholism and Drug Dependence (SANCA). The challenges pertaining to the NDMP result in bottlenecks in the rendering of services which further worsens the scourge of SUDs and relapse rates in the country. For instance, if there are no resources, it means there are no means of following up on service users which further results in them going back to substance abuse during or after treatment.

3.3.4 The Integrated Service Delivery Model (ISDM)

The Integrated Service Delivery Model (ISDM) is founded on a developmental paradigm, whereby service users are viewed as possessing inner strengths with the capacity for growth and self-development. It was put in place in order to guide and give structure to the rendering of social services in South Africa. Furthermore, it gives clarity on the nature, scope and level of services in the developmental social services sector, which has been unclear for a long time. The desired outcome of the ISDM is

the implementation of an all-inclusive, efficient, operative and quality service delivery that contributes to a society that is self-reliant. The ISDM opines that through cooperation and partnership among different stakeholders and service providers within the social services sector, coordination and role classification will be enhanced while duplication and fragmentation of services is prevented (DSD, 2006).

Although the ISDM has many strengths, its mandate has also been hindered by historic imbalances in service delivery in the country. Lombard (2007) posits that many sectors of social services have suffered as a result of social security taking the bigger chunk of the budget meant for the delivery of all social services. This has left a gap in the provision of prevention and early intervention services which has led to inadequate funding for NGOs, including those that render services to individuals with SUDs. It can be deduced that this 'gap' also affects the rendering of aftercare services for service users who have exited treatment, which consequently gives leeway to relapse.

The ISDM postulates that in order to attain the improvement in social functioning of service users, services are rendered at different levels which are on a continuum. It is left to the service user and the service provider to jointly determine the best suitable intervention strategy that will result in favourable outcomes for the service user. The levels of intervention include, prevention, early intervention, statutory intervention and aftercare. Before the levels of intervention in SUD treatment can be discussed, it is befitting to first give a preamble of the nature of treatment settings in South Africa as this would assist in understanding the context within which the interventions are implemented. Thus, the nature of treatment settings in South Africa are discussed next, followed by the levels of intervention.

3.4 THE NATURE OF TREATMENT SETTINGS IN SOUTH AFRICA

Under the Prevention of and Treatment for Substance Abuse Act 70 of 2008, the establishment of treatment centres for the rehabilitation of service users with SUDs is also provided for (RSA, 2008). For the purposes of this study and in line with the selected research participants, inpatient and outpatient treatment services in the treatment of SUDs are discussed next.

3.4.1 Out-patient service

According to the Prevention of and Treatment for Substance Abuse Act 70 of 2008, outpatient treatment service refers to a non-residential service provided by a treatment centre or halfway house to persons who abuse substances and to persons affected by substance abuse and which is managed for the purposes of providing a holistic treatment service. Such facilities should be registered with the Director-General, who is also empowered to deregister them if they do not comply with the recommended regulations (RSA, 2008). Currently, most outpatient facilities in the country are run privately while some are run by Non-Governmental Organisations that are subsidised by the government. Provincially, the Western Cape has 16 outpatient facilities, followed by Gauteng with eight outpatient facilities (DSD, 2015). SANCA is the most widely known Non-Governmental Organisation, with a presence of over 50 outpatient and inpatient treatment centres countrywide.

3.4.2 In-patient treatment service

Inpatient treatment service may take place in various forms. It may take place in a medical or psychiatric setting or a specialised SUD treatment facility. For the purposes of this study, inpatient treatment refers to residential treatment at a specialised SUD treatment facility. According to the Prevention of and Treatment for Substance Abuse Act 70 of 2008 Act, an in-patient facility is a residential treatment service provided at a treatment centre. The Act provides that for every province, the Minister, in consultation with the Member of the Executive Council (MEC) must establish, maintain and manage at least one public treatment centre for the reception, treatment, rehabilitation and skills development of service users with substance abuse problems (RSA, 2008). The Department of Social Development reported that in 2015 there were only seven State owned inpatient treatment facilities (DSD, 2015). One more such facility was opened in the Limpopo Province in 2018, bringing the number to eight.

The issue of which treatment setting is more effective between inpatient and outpatient treatment has long been the subject of a debate (McCarty, Braude, Lyman, Dougherty, Daniels, Ghose & Delphin-Rittmon, 2014). However, Mignon (2015) argues that the effectiveness or success of treatment is more dependent on the content of the treatment rather than on the treatment setting. The different opinions of different

scholars concerning the effectiveness of either inpatient or outpatient treatment are briefly discussed below.

3.4.3 Inpatient treatment service versus outpatient treatment service

Inpatient treatment service involves residence in the treatment facility whereas outpatient treatment service involves the client staying at their own place of residence while accessing services from the treatment facility (Dodgen & Shea, 2000). Mignon (2015) maintains that inpatient treatment does more than just give the client a break from family and work responsibilities, it also allows a greater level of medical supervision that can help them become increasingly aware of the triggers that can precipitate relapse. Ramlagan et al. (2010) posit that outpatient treatment contributes to high relapse rates because treatment professionals have little control over the service user and also because in their going back and forth, the service user is susceptible to influence to abuse drugs. Conversely, Ogborne, Sobell and Sobell (1985) argue that outpatient treatment should actually be the treatment of choice whenever possible because of its ability to allow the client to function in the natural environment which allows the treatment professional to evaluate the client's ongoing functioning. The Cape Town Drug Counselling Centre (2007) concurs that outpatient treatment is more effective than inpatient treatment with regards to helping the client maintain sobriety. Under the outpatient treatment setting, the client develops new skills and learns to cope with everyday life stressors while accessing support and guidance during treatment. In contrast, during inpatient treatment, the service user is taken away from the real world and expected to come back and maintain sobriety. The argument is that, the client from an inpatient facility hardly learns the means with which to cope with high risk situations.

Lessa and Scanlon (2006) maintain that while inpatient treatment is often regarded as more effective than outpatient treatment, its main drawback is the fact that after being discharged, the individual often experiences a "pink cloud" period whereby they have to balance their will to stay clean and sober with real life challenges. The client returns to a world where the idea of their last high begins to be more appealing. Dodgen and Shea (2000) also point that despite being more extensive and intensive than outpatient treatment, inpatient treatment is generally costlier. It can therefore be inferred from the above argument that outpatient treatment seems to be more favourable in terms of

cost and allowing the service user to rehabilitate while in his habitual environment. Additionally, outpatient treatment may also have the advantage of continued support for the service user from their significant others. Given the nature of SUDs and factors that influence relapse, inpatient treatment would seem favourable in that it takes the service user away from the substances until such a time when they no longer crave to use them again. Manuel et al. (2016) are of the view that, inpatient treatment is more suited for individuals with chronic SUDs, as it affords intensive services combined with safe accommodation and assistance with daily living, which seems to boost post-discharge substance use outcomes. Either way, it seems that the effectiveness of each of the treatment settings is highly dependent on a number of factors such as the service user's substance of choice, the availability of support or lack thereof. The levels of intervention in terms of the ISDM are discussed below.

3.5 LEVELS OF INTERVENTION IN RENDERING SERVICES FOR SUDs IN SOUTH AFRICA

The rendering of services in the SUD field in South Africa has been marred by inconsistencies and undocumented outcomes. Shokane, Nemutandani and Budeli (2016) posit that this is worsened by a virtually non-existent information management system which significantly impedes planning. There is very little analysis or commentary on the levels of intervention as stated in the ISDM (2006).

The ISDM was developed with the wider view to oversee and address the service delivery system in the social development sector. It defines services in two broad classifications that constitute developmental social services; developmental social welfare on the one hand and community development on the other. Developmental social welfare is further narrowed down in terms of levels of intervention which overlap in practice. The main goal of these services is to encourage optimal functioning of the service users and ultimately enable them to safely go back and fit into society. The ISDM emphasises that the client is not an impassive recipient of services but rather an active participant with the propensity to realise their own desired level of functioning. The levels of intervention are divided into prevention, early intervention, statutory, and reconstruction and aftercare services. Under the levels intervention, there are also core services which include promotion and prevention, protection,

rehabilitation and continuing care as well as mental health and addiction services. These issues are discussed under their respective levels of intervention below.

3.5.1 Prevention

The ISDM postulates that this is the key component of service delivery whereby services are rendered with the broader aim to strengthen and build the capacity and self-reliance of the client, who has not yet necessarily indulged in risky behaviour but may be at risk (DSD, 2006). The UNODC (2017) is agreeable that the main goal of prevention services is to help avoid or delay onset of substance abuse to those individuals that have not yet started. It also allows for a healthy and safe development away from drugs and substances, especially for children and the youth.

Promotion and prevention services fall under the prevention level of intervention. These are core services primarily aimed at preventing anticipated undesirable situations. The main objective is to work towards the upliftment of all people by helping them make healthy choices and find ways of sustaining those choices. In terms of substance abuse, these may comprise programmes for the prevention and treatment of substance abuse, community awareness programmes as well as the implementation of the National Drug Master Plan 2013-2017. Services are targeted at all levels of society, children, adults and the elderly (DSD, 2006). The Prevention of and Treatment for Substance Abuse Act 70 of 2008 indicates that prevention services should also focus on empowering communities to understand and be able to deal with challenges related to substance abuse such as crime and HIV and AIDS as well as creating consciousness and educating the general public on the dangers of substance abuse (RSA, 2008).

3.5.2 Early intervention (non-statutory)

Services at this level of intervention earmark those that have been identified to be at risk so that they are assisted before they require statutory services or more intensive intervention (DSD, 2006). For instance, early intervention services may be offered to high school learners who have been found experimenting with any sort of substance. The intervention in this case would be aimed at making sure that they do not continue to indulge in substances to a point where it will interfere with their academic, family or social wellbeing.

Under early intervention, **protection services** are the core services mainly intended to protect the well-being of individuals and families. This can be done within the context of a legislative and/or policy framework. Certain people or institutions are given the mandate to take specific actions as they reckon necessary to protect the integrity and well-being of the person within the social context of the family and community. Protection services' primary purpose is to ensure the wellbeing and safety of families, children and individuals (RSA, 2006). For instance, when the law instructs that an educator who has a severe substance use disorder be committed to inpatient treatment, this does not only protect the said educator but also the community at large as the educator may, due to maladaptive behaviour caused by the substance use disorder, hurt themselves or any member of the community.

3.5.3 Statutory intervention/residential/alternative care

Services rendered on the statutory level are directed to clients who are no longer able to function adequately within the community or are at loggerheads with the law for one reason or another. As a result, the client at this level of intervention may have to be removed from their usual place of habitation, by either a court interdict or as a recommendation by a service provider, to alternative care or in the case of a substance use disorder, to an inpatient treatment facility (DSD, 2006).

Rehabilitation services are core services under the statutory or residential level of intervention that are focused on the improvement and maintenance of the social functioning of clients who may be affected as a result of injury, disability or a certain chronic condition. These services do not only improve the quality of life of the affected individual client, but they are also an operative means of the burden on families and government subsidised support systems. These services may be rendered in wide-ranging settings, which may include the home, service agencies and residential facilities. For example, in the context of substance abuse treatment, referring a service user for treatment reduces the burden on the family, which has to deal with the service user's stealing their belongings in pursuit of their next "fix". Under this basket of services, the focus is on helping the individual to return to their normal functioning and foster a healthy and responsible lifestyle (DSD, 2006).

3.5.4 Reconstruction and aftercare

Following successful intervention at the statutory, or alternative care level of intervention, the client is meant to smoothly move to the reconstruction and aftercare level of intervention, where they are enabled to re-join the family or community. At this level, services are aimed at reintegrating the client back to the community and fostering self-reliance for optimum social functioning (DSD, 2006). The Prevention of and Treatment of Substance Abuse Act 70 of 2008 (RSA, 2008) defines aftercare as continuing professional support to a service user following a prescribed treatment in order to enable them to maintain sobriety or abstinence, individual growth and to augment self-reliance and appropriate social functioning. For many service users, being involved in an aftercare programme in the form of self-help support groups such as the Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) has worked as a useful support structure whereby the client accesses continuous services for optimal functioning which has led to the reduction of relapse (SAAMS, 2015; Blonigen et al., 2015).

Individuals who, for one reason or another are not able to care for themselves totally, are catered for through the **continuing care and the mental health and addiction services** core services under the reconstruction and aftercare level of intervention. In an integrated fashion, the individuals are assisted in maintaining or improving their physical, social, and psychological wellbeing as well as their independence and quality of life. The system is made flexible and progressive enough to allow for easy accessibility of required services with little or no intrusion for a greater chance of sustainable and functional independence. In the context of substance abuse, the management of government treatment facilities falls in this category (RSA, 2006).

The intervention methods for SUD treatment will be discussed next.

3.6 INTERVENTION METHODS FOR SUD TREATMENT

Due to their chronic nature, SUDs have been found not to be easily treatable by applying only one form of treatment, meaning that a combination of various treatment methods and regular monitoring is necessary for treatment to be successful. Individual needs and the substance of choice play a part in the type of treatment a client may require. The severity of the SUD, comorbidity as well as the history of treatment also

play a role in the selection of a suitable treatment plan. The best intervention methods for SUD treatment are those which integrate different therapies, tailor-made for a specific client (Miller, Forcehimes & Zweben, 2011; Wloch, Ksiazek, Warchol-Slawinska, Drop & Falkowski, 2014). The treatment of SUDs is targeted on the service user as a whole, their physical as well as psychological well-being. There are two broad methods of intervention generally used in the treatment of SUDs; psychosocial intervention methods and medically assisted intervention methods.

Psychosocial intervention methods target various aspects, like the service user, the family as well as processes involved in the addiction. They are also aimed at stimulating changes in the service user with regards to their substance use through close interaction between the treatment professional and the service user. Medical interventions on the other hand are often focused on the neurophysiological processes underlying addiction, such as the effects of the substances on the brain (Bukstein & Cornelius, 2006; Jhanjee, 2014). Medically assisted interventions have three broad objectives; management of acute withdrawal syndromes through detoxification, lessening of cravings and urges and prevention of relapse (O'Brien, 2005). Carroll and Kiluk (2012) posit that while there is evidence that both methods of intervention may work independently in the treatment of SUDs, there is a general consensus that a combination of the two yield the best outcomes. SAAMS (2015) also notes that regardless of the type of intervention finally decided upon, ancillary psychosocial support for all service users is indicated and strongly recommended. Additionally, the provision of medical treatment without offering any psychosocial assistance is tantamount to ignoring the complex nature of SUDs. This may result in loss of the prospect of providing optimal interventions best suited for the client because all treatment services should be aimed at offering immediate, integrated and inclusive psychosocial support to every client (SAAMS, 2015). In the next section, psychosocial and medical interventions in the treatment of SUDs are discussed.

3.6.1 Psychosocial intervention methods

Psychosocial intervention methods in the treatment of SUDs help provide clients in recovery with motivation and skills to maintain abstinence. Some of the most widely studied and applied psychosocial interventions include Cognitive Behavioural Therapy (CBT), Motivational Interviewing (MI), the Matrix Model as well as 12-Step

Programmes. Their effectiveness varies according to different factors such as the client's life contexts, their substance use behaviour as well as their social and personal resources. Research has found that in South Africa, there is inadequate access to empirically supported treatments and a deficiency of trained treatment professionals to deliver evidence-based treatments. Most treatment interventions such as the Matrix Model are tested and widely applied overseas, especially in the United States of America (USA) before they are adopted in South Africa. This raises a concern whether evidence of the efficacy of such methods in the developed countries like the USA can be effectively extended to countries such as South Africa which are still struggling and developing in terms of SUD treatment (Myers, Louw & Fakier, 2008; SAAMS, 2015; McCrady, 2014; Jhanjee, 2014; Blonigen, Finney, Wilbourne, & Moos, 2015). The Cognitive behavioural therapy will be discussed first, followed by Motivational Interviewing, 12-Step Programmes and the Matrix Model last.

3.6.1.1 Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) is an overarching term for various therapeutic systems that share similar elements. Cognitive behavioural therapies emanated from the classical behavioural theory and the ground-breaking works of theorists such as Pavlov, Watson, Skinner and Bandura. They are among some of the most precise and thoroughly studied psychotherapeutic interventions for SUDs. They have been found to be effective not only for the treatment of SUDs, but also for various other disorders, especially those that co-occur with SUDs, like depression and anxiety (Sorensen et al., 2009; Galanter, Kleber & Brady, 2015). A hallmark feature of all CBTs is their pursuit to help the client pinpoint their irrational thoughts and eventually correct them (Doweiko, 2015). Although SUDs have a reputation for relapse, especially given the prevalence of comorbidity with other mental health problems, CBTs have been proven to increase the client's motivation for change, thereby reducing the risk of relapse (Freeman et al., 2004). Two critical components stand out in CBT for SUDS; functional analysis and skills training. While functional training is used to identify and assess the individualised circumstances that are likely to lead to substance use and provide insights into some of the reasons leading to substance use, skills training focuses on helping the client to unlearn old habits associated with drug use. CBTs represent a synthesis of the behaviour and cognitive therapies and can be applied in both

individual and group contexts. While CBT fosters client-specific needs in the tailoring of the treatment plan in individual therapy, within a group setting, it also allows for the sharing of ideas and coping strategies.

3.6.1.2 Motivational Interviewing (MI)

Diclemente, Kofeldt and Gemmell (2011) note that several interventions and strategies have been developed to motivate the client throughout the process of recovery, but one of the most well-known and applied is motivational Interviewing (MI). MI is defined as a concerted goal oriented style of communication which pays specific attention to the language of transformation. It is a type of communication tailored to entice and strengthen another individual's personal impetus for and commitment towards a precise goal within an accepting and empathetic environment. It was developed around the 1980s by Miller and Rollnick in response to what was considered exceedingly offensive approaches to treating SUDs. To date, it is the parent intervention that has informed many of the brief motivational interventions and is also one of the most comprehensive and well established treatments based on evoking the client's own motivation to change. MI rests on the premise that people have an innate drive to seek healthy and productive ways of living (Finney, Moos & Timko, 2013). Primary elements of MI involve expressing empathy for clients, assisting them to realise that there are inconsistencies between their goals, values and behaviour (Doweiko, 2015).

Although it was initially developed for alcohol use, MI has also been widely adopted and proven to be successful in the treatment of other SUDs and many other behavioural problems beyond substance use. It rests on a collaborative effort between the client and the treatment professional in exploring whether change would be worth making as opposed to the professional imposing themselves or advising the client to change. One of its most outstanding strengths is that it encourages the process of self-change and boasts efficacy, conciseness and suppleness (Finney et al., 2013). MI seeks to modify behaviour through collaborative conversation whereby the client is given the opportunity to discover their own instinctive capabilities to make the right decisions and commit to change (Smith, 2015). Finney et al. (2013) submit that although it has been widely applied, MI has been found to be lacking in the area of having a theory on how motivation should be evoked, leaving it vulnerable to criticism

with regards to its plausibility and effectiveness. However, Sorensen et al. (2009) argue that as a short-term client-centred directive intervention which allows clients to explore and resolve uncertainty about change, MI has presented modest levels of effectiveness in the treatment of SUDs. Mignon (2015) adds that MI can be applied in both inpatient and outpatient treatment facilities.

Lassiter and Culbreth (2013) outlined the fundamental tenets of MI. They emphasised the importance of ambivalence, its goals, ways in which it can be applied as well as how practitioners that subscribe to it employ it in their practice.

- *The importance of ambivalence*

Motivational Interviewing boasts a massive contribution in its recognition of ambivalence about changing behaviour. It recognises the fact that whenever there is consideration of change, there is bound to be an emotional reaction because it is only natural that one would think twice before they turn their back on a long-term habit. Contrary to the traditional way of viewing ambivalence as resistance that is punishable, MI views ambivalence as a natural reaction to change. It recognises, explores and helps the ambivalence in an enabling environment that allows the client freedom to change (Sobell & Sobell, 2011; Lassiter & Culbreth, 2013).

- *Goals of MI*

Three main goals inform the MI practitioner. The first goal is to assist clients to increase their intrinsic motivation to change substance use behaviour. This, key to MI, is based on the fact that the motivation that emanates from within gives the client a sense of autonomy which will help them sustain the change for longer as opposed to the motivation that is externally controlled and only stimulates action. MI practitioners therefore capitalise on this peculiarity by employing strategies that help clients to look internally for the drive they require to accomplish their goals. Clients are assisted to resolve their ambivalence, all the while allowing for client choice and control in redeploying their efforts on needs, desires and reasons for change. The second goal of MI is to help minimise discord. When there is less discord, there is room for new insights, behaviours and possibilities in the client's life. The third goal pertains to helping clients to deal with ambivalence. The practitioner's role in achieving this goal is to use strategies that will assist the client to explore and resolve their indecisiveness

in a swift movement towards change. For instance, a client might know that the continued use of substances will have dire consequences for him/her but at the same time still know how relaxed they feel after using substances. This puts the client in a place of indecisiveness which may explain why most people remain stuck in problematic behaviours (Lassiter & Culbreth, 2013).

- *Ways to implement MI*

Motivational Interviewing can be employed in many different ways. It can be used as a stand-alone strategy, as the first step to escalate motivation or as a strategy to fall back to when necessary. When used on its own, MI is characteristically used as a brief counselling modality of about three to five sessions although it can still be applied for longer. As an initial strategy, it can be used to assist in escalating motivation and lessening discord. Motivating the client first is crucial before moving to other approaches intended to facilitate change. Lastly, throughout the course of intervention, MI can be employed whenever the client seems to lack motivation to change (Lassiter & Culbreth, 2013).

3.6.1.3 12-step programmes

Twelve (12) step programmes offer the platform for people in recovery to connect with one another in an environment that endorses long term recovery. The hallmark of 12-step programmes is abstinence for those who want to quit substances but have tried to do so alone and failed. There are many different types of 12-step oriented-treatment programmes, but they share the same characteristics. These include the AA, NA, and Gamblers Anonymous (GA). The AA is widely recognised as the prototype for all the other self-help support group. It was founded by Wilson and Smith (1935) as a method to help people achieve and maintain sobriety (Rasmussen, 2000).

In the 12-step programmes, self-knowledge is of paramount importance, whereby the client shares their weaknesses and strengths with regards to their SUD, with at least one other person. They stress awareness of emotions, attitudes and actions that may dispose the client to an active relapse process because the client is viewed to be always in the recovery process as opposed to being fully recovered (Rasmussen, 2000; Wallace, 2012). The 12-step programmes provide their clients with a powerful outlet, whereby clients can freely explore their experiences, grow and learn new skills

in a predictable and non-threatening environment. The emphasis from the AA model is the need for total abstinence and an acceptance that addiction is a life-long disease that requires a lifelong commitment to keep at bay (Blonigen et al., 2015).

3.6.1.4 The Matrix Model

The Matrix Model is an integrative style of treatment aimed to assist the service user to attain abstinence, psychological and physical wellbeing. It was initially designed around the 1980s in Southern California as an intensive and highly structured outpatient programme to treat service users with stimulant use disorders when the use of drugs such as cocaine and methamphetamine was endemic, but has now been adopted for the treatment of many other SUDs (Obert, London & Rawson, 2002; Pates & Riley, 2010; Obert, McCann, Marinelli-Casey, Weiner, Minsky, Brethen & Rawson, 2011). It is mainly based on the original Cognitive Behavioural Relapse Prevention Model of Marlatt and Gordon (1985) and mainly aims to teach the skills needed to treat addiction and support strategies to family members through a sixteen week programme (Witkiewitz & Marlatt, 2007). The helping professional gives direction and fosters positive behaviour change by employing treatment strategies that are clinically proven (Obert et al., 2011).

Although the Matrix Model has been found to be highly effective in understanding the trajectory of addiction, some studies found out that perhaps its major drawback yet is the fact that it is long, expensive and requires intensive staff training. This could possibly explain why it has been scarcely employed as a method of treatment in South Africa specifically. It was not until 2007 that the Matrix Model of outpatient treatment was first introduced in South Africa, in Cape Town. Another serious bone of contention is that; the Matrix Model has been proven to be highly effective in the United States of America, where it has been widely tested, but there has been very little recorded evidence of its efficacy and applicability in a country like South Africa where there are still innumerable barriers to substance abuse treatment (Gouse et al., 2016). Obert, et al. (2002), contend that if the complex scientific information of the Matrix Model can be broken down and streamlined for use with clients and their families, it would assist in moderating client confusion about their own behavior and also help family members to appreciate and support the efforts of individuals in recovery.

The Matrix Model is highly structured and combines various therapeutic strategies that work together in a coordinated fashion to form an integrated outpatient treatment programme (Ghasemnezhad, Ghasemian, Gheyarani, Ghorbani & Ghahari, 2016; Rawson & McCann, 2014). Its various components and therapeutic constructs as detailed by Rawson and McCann (2005) will be discussed next. *a) Individual counselling*

Individual sessions form the basis of the development of rapport between the service user and the helping professional. The content of the sessions is mainly focused on setting and checking on the progress of the service user's individual goals. Sometimes, the significant others can be involved in the treatment plan with extra lessons included when there is a crisis. The individual sessions cement the continuity of the primary treatment partnership and retention of the patient in the treatment process (Rawson & McCann, 2005).

Within individual counselling sessions, there should be a collaborative relationship between the helping professional and the service user, whereby the helping professional maintains a directive yet client-focused therapeutic standpoint. The service user should be treated with warmth, dignity, respect and genuineness, without imposing judgement. When the service user with an SUD is treated with dignity, they are encouraged to acknowledge their own self-worth and realise the need to work towards sobriety. When the relationship is imposing and confrontational, it may lead to premature termination of the treatment. An involved service user is an active participant in their own recovery journey, which in turn fosters lasting change (Rawson & McCann, 2005).

a) Early recovery skills groups

The early recovery skills groups are designed for those in the first month of treatment as well as those that need more tutoring on how to stop using substances. The early skills sessions are delivered in group sessions that are mainly aimed at capacitating service users. The main areas covered include, how to use cognitive tools to reduce cravings, the nature of classically conditioned cravings, time management, the need to abstain from secondary substances and to link service users with community support systems that are necessary for successful recovery. The groups are kept

relatively small in order to allow for individual interaction between the service user and the helping professional (Rawson & McCann, 2005).

Structure is a key component in any effective treatment programme. The service user's activities that are part of their treatment involvement constitute the structure in outpatient settings. The activities include attendance of individual and group sessions, participation in community self-help groups and the scheduled daily activities that help reduce contact with substances and other risk situations. Structure in a treatment setup helps the service user to know what is expected of them and also provides a clearly marked path to recovery. The information given helps to reduce anxiety and stress while providing consistency and predictability as opposed to a chaotic, unstructured and unplanned lifestyle that most service users with substance use disorders are used to. The main aim of providing structure is to help the service user in recovery to learn to stay in abstinence a day at a time. However, structuring may come with some challenges. For instance, when leisure and relaxation time is not included in the schedule, it may lead to noncompliance. It means that the schedule should be realistic and created to accommodate the service user's normal routine without substances. Another challenge could be that some service users find it difficult to make an hourly schedule. This can be solved by simplifying the schedule and dividing it into four sections throughout the day. Furthermore, some families may want to dictate the service user's schedule, this may include spouses or parents who have a lot to say about the things that have long been neglected. This becomes problematic when the service user complies for the sake of peace, eventually they will start to view the helping professional as a colluding compatriot, which may consequently affect the recovery process. It is therefore important that the schedule be particularly constructed by the service user themselves with inputs from the helping professional (Rawson & McCann, 2005).

b) Relapse prevention groups

Relapse prevention groups as a component of the Matrix run throughout the treatment programme on a weekly basis. They are aimed at teaching service users to maintain sobriety, which is one of the most difficult things to do for an individual with an SUD. Relapse prevention groups provide a non-threatening environment where service users learn and share information on relapse. The group sessions cover 32 topics that

are focused on behaviour change, changing thought patterns and connecting service users with 12-step programmes for continued support. The groups are structured with a consistent format which includes introduction of new members, individual feedback reports on progress in recovery, reading of the day's topic and relating it to personal experiences and sharing of the schedules, plans and commitment to recovery before the group disperses. The treatment professional's role during the session is to make sure that the session progresses smoothly without losing direction of the topic and its educational element. Sometimes an exercise called relapse analysis is employed when a service user relapses unexpectedly but is not conscious of the cause of the relapse. The optional exercises and forms are specifically designed to assist the helping professional and the service user to try and figure out the preceding events before the relapse so that it can be avoided in the future. The exercise is carried out in an individual session with the service user or sometimes with a significant other (Rawson & McCann, 2005).

Reinforcements are also used in the Matrix to encourage service users to continue in sobriety. For instance, as part of the programme, the helping professional gives incentives for drug free urine tests, attendance at treatment sessions, or achieving treatment goals at some point during the programme. Participants have received certificates that are redeemable for items with monetary value, and it has been determined that if combined with social recognition, relatively inexpensive items can have a strong effect on behaviour. Although it has been proved to be efficient, contingency management did not fully make inroads in the treatment field due its complexity and costs involved. The Matrix Model has tapped into the contingency management in a simple and inexpensive way. Rawson and McCann (2005) outline that specific behaviour targets vary from one programme to another depending on the needs and available resources, but some general features apply:

- The requirement for earning an incentive should be clear, detailed and specific.
- Behaviour should be verifiable. For instance, if urine tests are incentivised, they should be valid and testing procedures should be in place.
- There should be consistency in the application of contingencies, if rules are not consistent, they become ineffective.

- There should also be social reinforcement with other incentives, when accomplishments are acknowledged in groups, the effects are greatly magnified.

Examples of contingency management used in the Matrix programmes include abstinence, whereby at the beginning of each session clients place coloured stickers on a calendar for each day spent in sobriety. The public recording of data fortifies the achievement of gaining sober days. In other instances, whoever provides substance-free urine part takes in a Pizza Party at the end of the week. Sometimes attendance is rewarded by giving out a gift voucher during the session, while those that show up for the group are treated to Cookies or Chocolates that are put out 5 minutes prior to the session and are left out until 5 minutes later. Another example is rewarding good behaviour during group sessions by giving out stickers which are put on the treatment binder. The behaviour can vary from saying something supportive of another member, abiding to group rules for the entire group session, to saying something reflective of a positive change in attitude or recovery behaviour. The cost of the incentives is usually very small and can be offset by attendance fees or subsidies from local merchants (Rawson & McCann, 2005). The idea of rewarding sober days as part of treatment for SUDs could also be easily applicable in South Africa as it basically involves non-expensive incentives such as Pizza and Chocolate. The facilitator can use whatever reinforcements are available in their context. For instance, a school social worker may use stationery to incentivise group members for maintaining sobriety. These can easily be accessed through the school system or kind donations from locally based stationery shops. Moreover, the publication of data with regards to days spent in sobriety within a group context could also foster positive competition whereby clients thrive to come out at the top of the list of the most days spent in sobriety.

c) Family educational groups

Family support is an important part of SUD treatment. When the family is well informed and made to understand the chronic nature of SUD, they are better placed to offer the necessary support that the service user needs to maintain sobriety. The family in this context includes everyone who is a part of the client's everyday existence, from biological family, close friends, partners and the extended family. The family group sessions follow a 12-week series that is delivered through the use of audio visual

materials covering different topics. The topics include the biology of addiction, conditioning and addiction, medical effects of drugs on the vital organs, how addiction affects relationships with the significant others. When families are successfully engaged in the family educational groups, there is an increased chance of keeping the service user in treatment for the entire treatment programme (Rawson & McCann, 2005).

A key component of the Matrix Model is information with regards to the neurobiology and conditioning of SUDs. Accurate and understandable information helps the service user to identify and normalise symptoms, which enables them to pull from resources and techniques to assist them to manage resources. Although using patient education as a treatment component is not a new phenomenon in the treatment of SUDs, the Matrix Model has taken it further by including the family and teaching them how the chronic use of substances can affect the brain functioning in a manner that influences the service user's behaviour. Information about the modifications that take place in the brain due to substance abuse is not easily understandable without scientific training to fully comprehend the concepts. Through psycho-education, the Matrix Model allows for the family, together with the service user to fully understand the brain chemistry in simple terms. The sessions run midweek during the family education group as part of a series of 16 educational groups. The challenge with the psycho-educational information based on science is that it can be boring and tedious to the service user and their families if it's not presented properly. The use of visual aids which also includes clear and understandable pictures and videos can be very useful in conveying the information so that the service users and their families can understand the relevance of the information and how it applies to the recovery process. The other issue with this concept is the fact that the presenter of the material should be well versed with the neurobiological concepts and other research material. Otherwise they will not be able to expand the information adequately enough to be relevant to the client's clinical challenges (Rawson & McCann, 2005).

When the family is fully educated on information around SUDs, they better understand the service user's behaviour before entering treatment and it also helps explain treatment and recovery. Also, the family is better prepared for the range of events such as lapses that may occur during the course of recovery. When treatment begins, family

members must decide whether they are willing to participate in the recovery process. The helping professional should schedule a family session in order to brief them on how they can be of assistance to the service user. If the helping professional's role is presented as that of providing support rather than entering therapy to address the family systems pathology, the family is likely to buy in. However, despite the recommendation by the helping professional, not all family members will want to get involved. This is often due to many different reasons, for instance, some may feel that they have been through enough already and cannot give another day to assisting the service user (Rawson & McCann, 2005).

d) Urine/Breath tests

The Matrix Model requires accurate information on the drug use status of service users throughout treatment and the most accurate means of monitoring substance use is the use of urine and breath alcohol testing. Nowadays, there are different testing methods which counts for efficiency and easy analysis of results. Notwithstanding the specific procedure used to run the test, the main aim is to monitor substance use and give feedback to the service user. Urine tests are carried out randomly once a week. Carrying out urine tests helps to keep track of the service user's patterns of substance use. Positive urine tests that reveal undisclosed use of substances are discussed constructively to avoid confrontation. Some service users may view the regular testing as a show of mistrust by the treatment professionals but this resistance may be allayed by explaining how testing can be to the advantage of the service user (Rawson & McCann, 2005).

3.6.2 Medical Interventions

The use of medications to treat SUDs is often referred to as Medication-Assisted Treatment (MAT). Although MAT was initially used for the treatment of opioid use disorder, it is now generally used for the treatment of alcohol use disorders and many other SUDs (McKay et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). While the treatment of SUDs with medications alone is reputable, there is now a general consensus that a combination of pharmacological and psychosocial approaches works much effectively (McKay et al., 2015; SAMHSA, 2018; NIDA, 2018a).

Medication helps in suppressing cravings associated with withdrawal from the specific substances used by the client and is administered according to what it should achieve. Some medications are administered specifically for stabilisation and maintenance, while the use of certain medications is used to block the effects of specific drugs. Either way, the main goal is to help the client to function normally without suffering from cravings, withdrawal symptoms, or any other side effects, which makes it easier for other aspects of treatments like behavioural therapy to continue (Carroll & Kiluk, 2012). Currently in South Africa, there is evidence of highly operative medications that are used to treat tobacco, opioid and alcohol use disorders (SAAMS, 2015; SAHMSA, 2018). However, Miller et al. (2013) notes that despite the availability of all these medications and many others in the treatment of SUDs, there are still some limitations. The client may refuse to take the medications out rightly or decide to stop taking the medications after a while. However, the authors further suggest that in circumstances like these, motivational interviewing may come in handy.

3.7 CONCLUSION

The combination of medical and psychosocial interventions in the treatment of SUDs has long been proven to achieve better and longer lasting treatment gains than when each intervention is applied in isolation. A lot has been done to improve SUD treatment the world over, including in South Africa. However, there still seems to be a gap in the application of locally based treatment methods that have been developed and tested in our own context. As it was found in the literature review, most treatment methodologies such as the Matrix Model have been widely applied and tested in the United States of America, with very little evidence of their efficacy recorded in our context. On the other hand, South African policy in the substances field also seems to be lacking, it seems good on paper but there are many gaps in the implementation of the provisions thereof. For instance, the limited inter-sectoral collaboration between State, civil society and the private sector in the implementation, monitoring and evaluation of the NDMP could be a contributing factor to the non-effectiveness and inaccessibility of treatment services as well as escalating relapse rates. The next chapter focuses on the findings of the study.

CHAPTER 4

VIEWS OF SOCIAL WORKERS REGARDING FACTORS INFLUENCING RELAPSE OF SERVICE USERS WITH SUDs

4.1 INTRODUCTION

This chapter flows from the third objective, which is to explore the views of social workers regarding factors influencing relapse. Chapter two provided an overview of relapse in Substance Use Disorders (SUDs) while chapter three described the intervention programmes and services rendered to service users with SUDs in treatment centres. The literature review in the foregoing chapters serves as a foundation for the empirical study. The research methodology adopted in this study is briefly discussed first, followed by the themes, sub-themes and categories according to the empirical outcomes.

4.2 RESEARCH METHODOLOGY

This section briefly outlines the key sections of the methodology executed in this study. These include, the research sample, research approach and design as well as data collection and analysis. The detailed methodology employed in the study is found in Chapter one.

4.2.1 Research sample

The research sample consisted of 20 participants. They were all social workers employed in substance abuse treatment NGOs in the Limpopo, Mpumalanga and Gauteng Provinces, respectively. All participants had a minimum of one year in the field of substances. Non-probability purposive sampling was used in the selection of the research participants. Strydom and Delport (2011) posit that purposive sampling allows the researcher to choose participants that are representative of the study population. The participants chosen fit into the following inclusion criteria:

- Registered Social Workers with the South African Council for Social Service Professions.
- Employed at a substance abuse treatment centre in the Limpopo, Mpumalanga and Gauteng Provinces.

- At least one-year working experience as a Social Worker in the field of Substance Abuse.
- Proficient in the English language.

4.2.2 Research approach and design

A qualitative research approach with an exploratory and descriptive research design was employed in this study. Fouche and Delport (2011) maintain that this kind of research design helps the researcher to explore and describe the experiences of the participants from the participants' frame of reference rather than that of the researcher. The views of social workers with regard to factors influencing relapse in substance use disorders were therefore explored and described objectively.

4.2.3 Data collection and analysis

A semi-structured interview guide was used as a means of data collection. Galletta (2013) maintains that a semi-structured interview helps draw data grounded in the experience of the participant as well as information directed by dominant constructs in the discipline within which the research is being carried out. A combination of telephonic and face-to-face interviews was used. Greeff (2011) maintains that, while telephone interviews have the advantage of less intrusion compared to face-to-face interviews, they also tend to be shallow in terms of the information given. To counter this stumbling block, the researcher briefed the research participants on the nature of questions beforehand. On the other hand, face-to-face interviews demand that the researcher be neither objective nor detached, the researcher must strike a balance between flexibility and consistency which is crucial in allowing for comparisons between stories shared by participants. Although the researcher was familiar with the context under discussion, she did not impose her own perceptions and beliefs on participants, thus there was no interference with the participants' views.

Gibbs (2007) mentions that qualitative data analysis involves transforming a voluminous amount of data and processing it through analytical procedures into clear, understandable, perceptive, dependable and original analysis. The different themes that emerged from the research interviews were transcribed using the denaturalised transcription style. The denaturalised transcript excludes all personal features from the conversation and focuses on the meaningful information that helps provide a more

comprehensive picture of the context of the study. Different themes that emerged were placed together and compared to existing literature before presenting the key findings of the research in a systematic and coherent manner (Maclellan-Lemal, 2008; Schurink et al., 2011; Oliver et al., 2005).

4.3 PROFILES OF PARTICIPANTS

An overview of the participants' profiles is discussed in this sub-section. The profiles are discussed in terms of the participants' age, gender, highest level of qualification, years of service in the substances field, training received as well as the nature of the organisation under which they were employed. The participants' demographic data is presented graphically in order depict a holistic view and analysis of the participants' profiles.

4.3.1 Age of participants in years

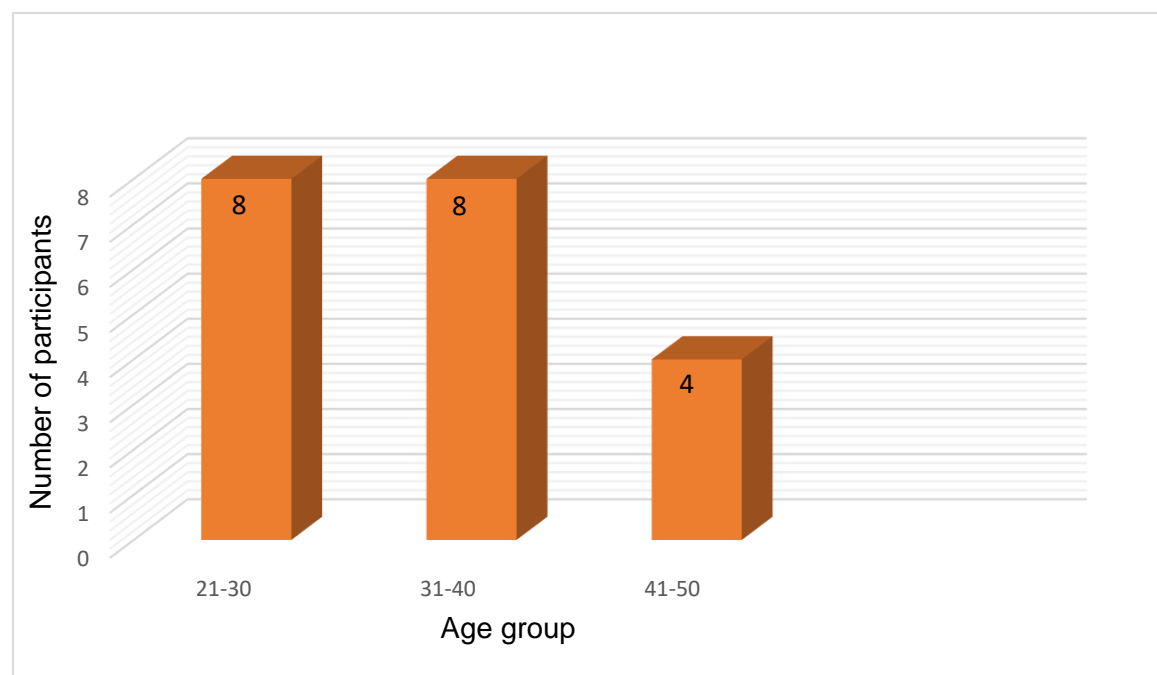


Figure 4. 1 Age of participants in years (N=20)

Most of the participants were between the ages of 20 and 40 years. Eight participants indicated that they were above the age of 21 but below 30 while another eight indicated that they were in the age of 31 to 40 years. Only four participants were between the ages of 41 and 50 years. Sodano, Watson, Rataemane, Rataemane, Ntlhe and

Rawson (2010) also found out that the average age of social workers in the field of substances is usually less than 40 years.

4.3.2 Gender of participants

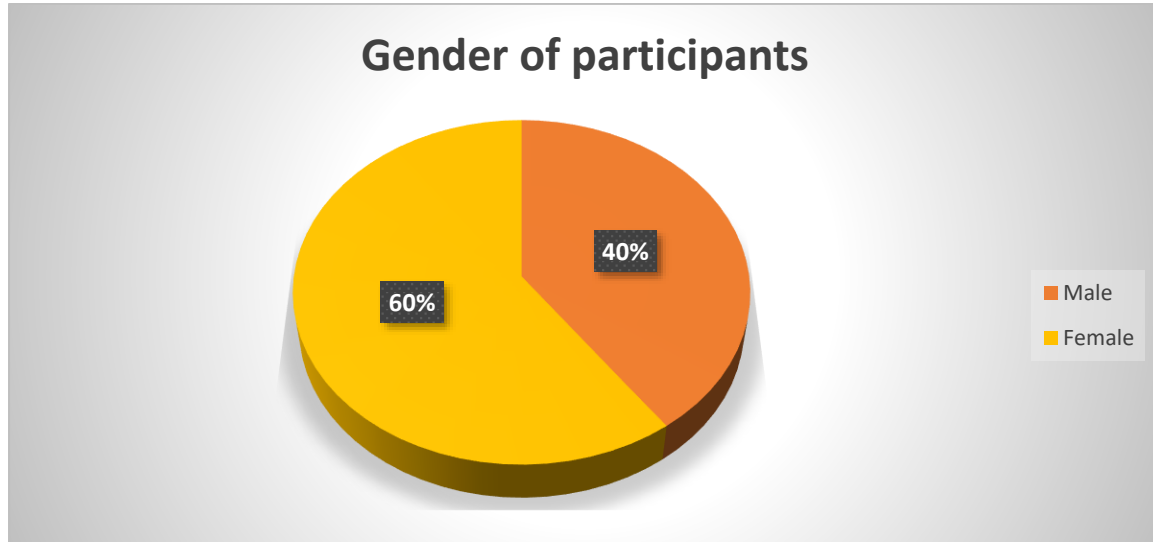


Figure 4. 2 Gender of participants (N=20)

Twelve of social workers who participated in the study were female while the remaining eight were male. Van Der Westhuizen (2010) found out that most social workers in the field of substances are female. Khunou, Pillay and Nethononda (2012) posit that caring professions such as social work, nursing and teaching have always been viewed as women's work, hence the majority of the participants were females. The researcher concurs with this notion as she also observed in her own organisation that females outnumber males by far.

4.3.3 Highest level of qualification

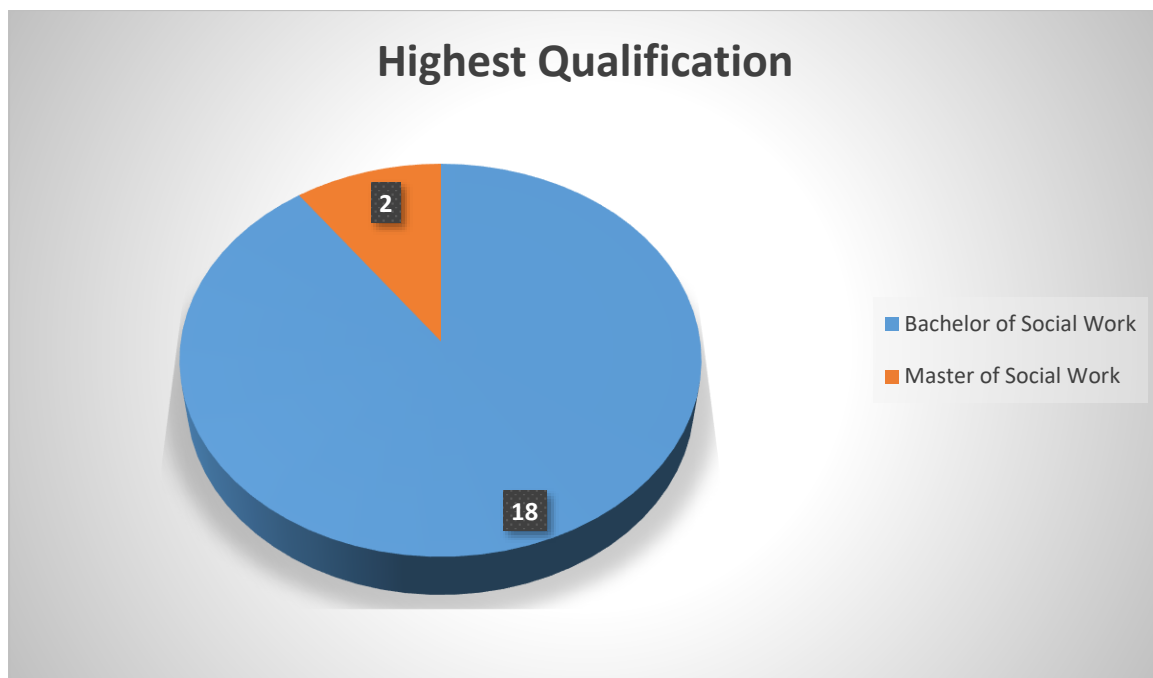


Figure 4. 3 Participants' highest level of qualification (N=20)

Two social workers from the study sample indicated that they had a Master's degree in social work while 18 indicated that they had a Bachelor of social work degree qualification. This is consistent with what Van der Westhuizen (2010) and Apollis (2016) have found out in their studies that the majority of social workers in the substances field have a four-year qualification in social work.

4.3.4 Years of experience

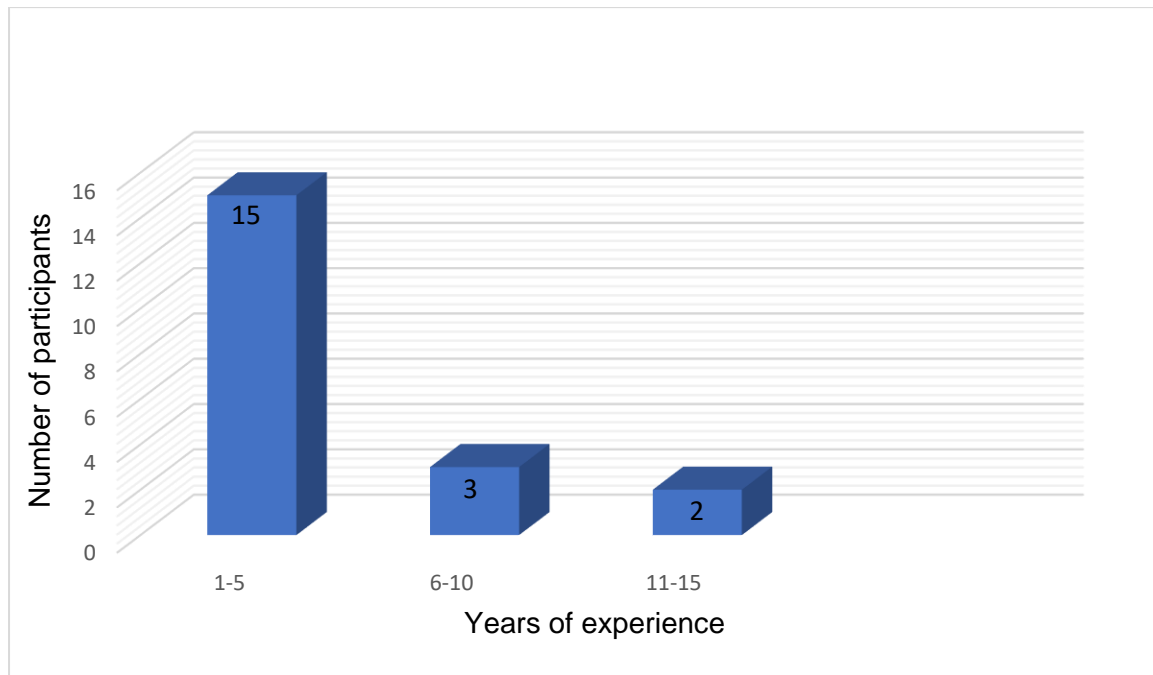


Figure 4. 4 Participants' years of experience (N=20)

From the data above, it is evident that the majority of social workers (75 %) had been in the substances field for five years or less. Only two of the participants had over eleven years of specialised substance abuse treatment experience. It is therefore not surprising that Sodano et al. (2010) found out that the average work experience for social workers in the treatment of substance use disorders was 5 years.

4.3.5 Training in Substance Use Disorders treatment

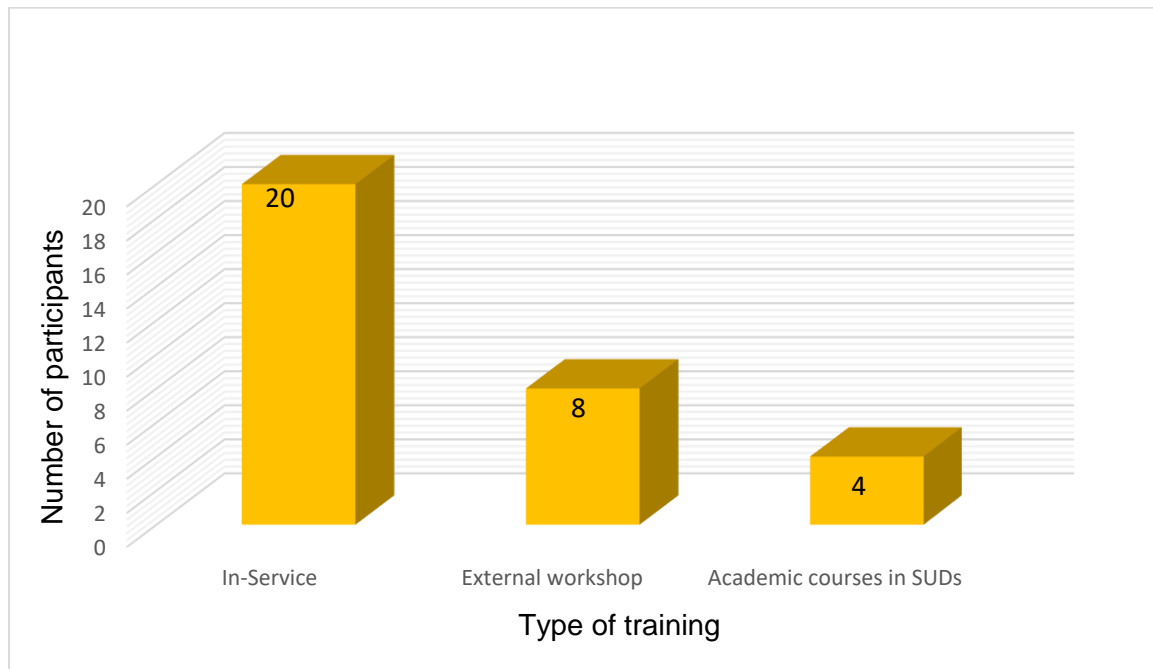


Figure 4. 5 Type of training received by participants (N=20)

**Participants could give more than one response *Total responses = 32*

All the participants indicated that they had received in-service training while some received training through external workshops and academic courses such as the short course in Identification and Management of Substance Related Disorders offered at the University of South Africa (UNISA). According to the participants, all in- service trainings were funded by their respective organisations. Meanwhile, the costs for the academic courses in SUDs attended by a few of the participants were incurred by themselves. The financial constraints could perhaps be the reason why the majority of the participants had not attained additional academic training on SUDs. Slabbert (2015) maintains that the substances field is a specialised one and social workers need knowledge and insight into the complexity of substance use disorders as they will have to deal with the consequences of substance abuse in one way or the other. Slabbert's views are gaining ground as institutions such as the University of Cape Town (UCT), Stellenbosch University (SU), University of the Witwatersrand (WITS) and the University of South Africa (UNISA) have started to incorporate substance abuse courses into their curricula (UCT; WITS; SU; UNISA). This is a sign that the call for substance abuse training in institutions of higher learning is receiving attention in the country.

4.3.6 Nature of treatment setting

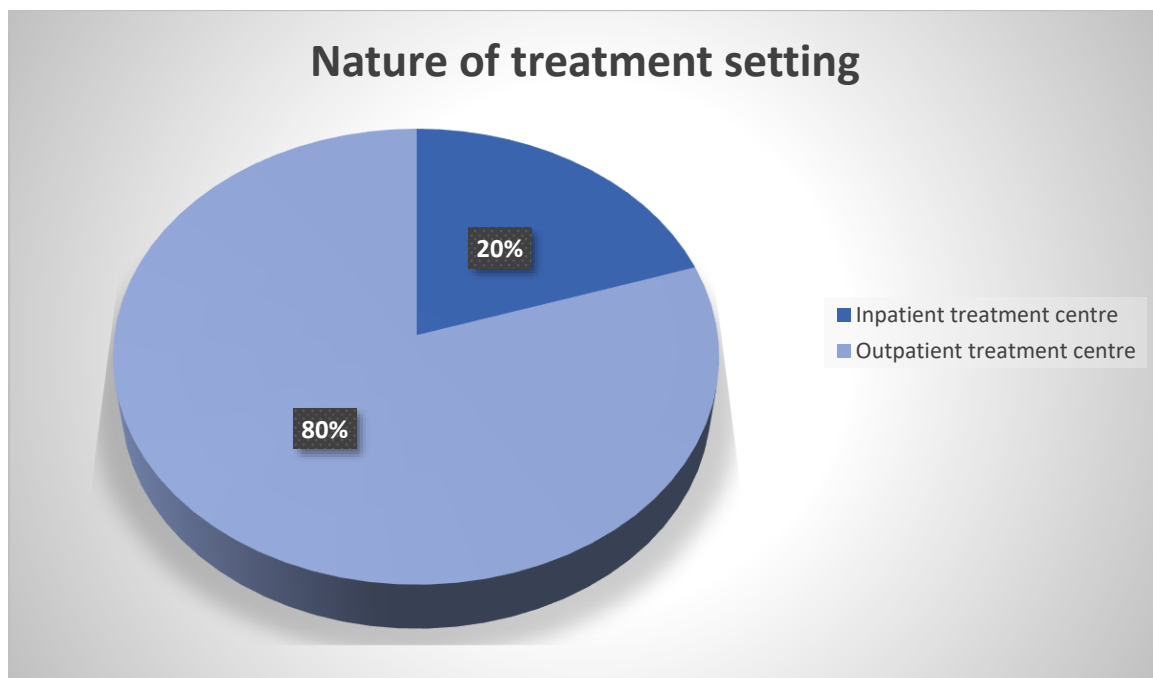


Figure 4. 6 Nature of participants' treatment setting (N=20)

Sixteen of the participants interviewed were in the employ of outpatient treatment centres. Only 4 were employed at an inpatient facility. This correlates with a report by DSD (2015) that there are more outpatient facilities in the country than inpatient centres. Some of the factors contributing to this status quo is lack of infrastructure, specialised multidisciplinary team and limited funds to setup inpatient facilities.

4.4 PRESENTATION OF THE EMPIRICAL FINDINGS

In this section, the empirical findings of the study are discussed. Seven themes emerged, namely; relapse in substance use disorders (Theme 1), factors influencing relapse from an ecological perspective (Theme 2), relapse prevention strategies from an ecological perspective (Theme 3), participants' perceptions on the nature and scope of SUD treatment in South Africa (Theme 4), services for SUD treatment rendered in terms of the ISDM (Theme 5), Intervention methods for treatment of SUDs (Theme 6) and recommendations for improvement of social work services in the substance abuse field (Theme 7). The themes, sub-themes and categories are discussed as shown in Table 4.1 below:

THEMES	SUB-THEMES	CATEGORIES
1. Relapse in individuals with SUDs	1.1. Prevalence of relapse	
	1.2. Profiles of service users prone to relapse	
	1.3. Substances that mostly lead to relapse	
	1.4. Period of relapse following treatment	
	1.5. Effects of relapse in society	<ul style="list-style-type: none"> • Family instability • Crime escalation • Waste of fiscal resources • Doubts on effectiveness of SUD treatment
2. Factors influencing relapse in individuals with SUDs from an ecological perspective	2.1. Factors on a micro-level	<ul style="list-style-type: none"> • Poor social support • Premature termination of treatment • Use of ineffective coping skills • The chronic nature of SUDs • Stage at which service users seek treatment • Poor attendance of aftercare programmes
	2.1 Factors on a meso-level	<ul style="list-style-type: none"> • Stigma from society • Availability of substances in the service user's immediate environment
	2.2 Factors on an exo-level	<ul style="list-style-type: none"> • Inadequate time spent in treatment • Inadequate diagnosis of comorbid disorders • Lack of family involvement in service user's treatment process • Poor quality treatment services

	2.3 Factors on a macro-level	<ul style="list-style-type: none"> • Inadequacy of inpatient treatment facilities • Lack of specialised knowledge among treatment professionals
3 Relapse prevention strategies from an ecological perspective	3.1 Prevention of relapse on a micro-level	
	3.2 Prevention of relapse on a meso-level	
	3.3 Prevention of relapse on a macro-level	
4 Participants' perceptions of the nature of SUD treatment in South Africa		
5 Services for SUD treatment rendered in terms of the ISDM	5.1 Levels of intervention in terms of the ISDM	<ul style="list-style-type: none"> • Prevention • Statutory intervention/residential • Reconstruction and aftercare
6 Intervention methods for treatment of SUDs	6.1 Psychosocial Interventions	
	6.2 Medical Interventions	
7 Recommendations for improvement of social work services in the substance abuse field	7.1 Incorporation of SUD modules at tertiary level	
	7.2 Declaration of SUDs treatment as a specialised field	
	7.3 Access to SUD information by service users and society at large	
	7.4 Application of South African based intervention methods in treatment centres	

	7.5 More investment towards SUD treatment	
	7.6 Improved intersectoral collaboration	
	7.7 Skills development programmes for service users	
	7.8 More research on SUDs	

Table 4. 1 Schematic presentation of the themes, sub-themes and categories

4.4.1 Theme 1: Relapse in individuals with SUDs

Under this theme, five sub-themes emerged. Firstly, the prevalence of relapse is discussed, followed by the profiles of service users prone to relapse, substances that mostly lead to relapse, period of relapse following treatment, and lastly, the effects of relapse in society. Some categories within the last sub-theme were identified and are also discussed below.

4.4.1.1 Prevalence of relapse

Participants were asked what the prevalence of relapse was in their service areas. Most of them indicated that relapse prevalence was high as indicated in these narratives:

“I can say it is high...it is there” (Participant 7).

“I definitely think its high” (Participant 16).

“Relapse is actually too high in this area” (Participant 2).

Consistent with the participants’ utterances, literature also reveals that relapse is the most widely noted outcome after treatment for psychological and substance use disorders. A bulk of service users that seek treatment are likely to experience relapse at some point (Witkiewitz & Marlatt, 2007; Kendler & Eaves, 2005). One participant went as far as mentioning that about half of the clients they treat for SUDs actually seek readmission as a result of relapse.

“I would say fifty percent of the people we assist are bound to experience relapse...”
(Participant 6).

Some studies have concluded that relapse will always be a part of the recovering process in SUDs (Witkiewitz & Marlatt, 2007; Robbins et al., 2010; Daley, Marlatt & Douaihy, 2011). The National Institute on Drug Abuse [NIDA] (2018a) posits that the relapse rates for SUDs are actually comparable to those of other chronic illnesses like Hypertension and Asthma. They further point that relapse in SUDs should not be treated as a treatment failure. Therefore, it can be suggested that the sooner it is accepted that SUDs are a chronic illness, the sooner and easier it will be for society to sympathise with individuals who relapse to SUDs which will in turn make way for a stronger support base.

4.4.1.2 Profiles of service users prone to relapse

After establishing that there is high prevalence of relapse in most treatment centres, participants were asked about the profiles of service users who mostly relapse in terms of race, gender and age. Their responses reveal that men who are mostly black and within the age range of 18 to 35 years are susceptible to relapse. The following are quotes to support these sentiments.

“Black, male mostly... anything from 18 to 35” (Participant 20).

“Mostly male, black...ranging from age 18 to 35, we never came across a case where a girl relapsed” (Participant 14).

“Youth is the most common... on the last statistics we submitted for last year, we saw over 3000 people and 2300 of them are youth and about one thousand something are male. In terms of race, most of them are black” (Participant 17).

Research has shown that relapse among young, black male service users is prevalent. Irrespective of the substance of choice or region, findings have been consistent across different provinces in the country (SACENDU, 2015; SACENDU, 2018; Swanepoel et al., 2016; Swanepoel, 2014). There is also evidence based on admissions to treatment centres that in the Northern and Gauteng regions, young black males constitute a bigger proportion of those that use heroin and Nyaope (SACENDU, 2017b). The

prevalence of relapse among young black males could be due to the fact that they are the highest population category that has access to treatment as repeatedly shown in SACENDU statistics (SACENDU; 2015; 2017a; 2018). Another reason for the prevalence of relapse among this age group could be due to the high incidence of substance use around this age. Afkar et al. (2017) found out that the highest frequency of people with substance use disorders are within the age range of 20-35 years, which is the youth.

Some of the participants highlighted the fact that it's not that women do not relapse or seek services but that there were certain barriers to accessing services.

It's not like females are not using these substances. They are, they are a lot and very young. The reason why we don't see them in our facilities is because our programme is not user friendly for ladies. Again, the issues of culture, if I'm going to be seen as a lady attending an outpatient centre or a day clinic or a rehab it's like a taboo...it is a lot of them (Participant 3).

With females it's not that they are not into substances, it's just that they are not seeking help...there are many females that use substances (Participant 11).

Myers, Parry and Pluddermann (2004) found out that women are underrepresented in treatment facilities, with 80 percent of people seeking treatment being male. This is mainly due to gender-related barriers to accessing treatment as opposed to low levels of substance use among women. Greenfield (2016) suggests that specific barriers and obstacles such as stigma, lack of support from partners and family, lack of child care for those who are parenting and insufficient financial resources are the main reasons why there is an underrepresentation of women in treatment centres. Furthermore, women who seek treatment are often stigmatised and are often turned away from treatment centres due to being pregnant or because of childcare needs. Females with SUDs are more negatively perceived compared to males. In most societies, substance use in females is usually associated with being sexually "loose", and the inability to fulfil traditional feminine roles. Subsequently, this often leads to females avoiding seeking treatment for fear of being labelled or having their children removed from them or being judged by the treatment providers. There is also evidence of negative perceptions towards women who use substances by health professionals and

community based organisations in South Africa (Myers, Fakier & Louw, 2009; Isobell, Kamaloodien & Savahl, 2015). Therefore, it is not surprising that the findings of this study reveal that it's mainly males who seek treatment for SUDs and often relapse, due to the stigma attached to women who seek treatment.

4.4.1.3 Substances that mostly lead to relapse

Regarding substances that cause the most demand for treatment, most participants mentioned Nyaope as the leading substance, with alcohol and dagga following closely. Some of the participants also made mention of other drugs such as Mandrax, Cocaine, KHAT, Crystal meth and Heroine, but they also highlighted that Nyaope was trending.

“Between dagga, alcohol and Nyaope, I’m struggling to pick one...” (Participant 12).

“Nyaope and heroine...Nyaope is the trending one...the biggest, dagga as well but Nyaope is actually used more” (Participant 9).

“95 percent is Nyaope. You do have these others like cocaine, mandrax, but mostly it’s Nyaope” (Participant 3).

SACENDU (2018) submitted that the most used substances in Gauteng and the Northern region (made up of Limpopo and Mpumalanga Provinces) were Cannabis (dagga), Alcohol and Heroine in the period January to June 2017. Ramlagan et al. (2010) also add that Alcohol, Cannabis and Cocaine are among the most frequently used substances. Kadam, Sinha, Nimkar, Matcheswalla and De Sousa (2017) suggest that Opiates and Alcohol rank top of the most addictive substances due to their biopsychosocial effect on individuals that use them. Nyaope seems to be the new drug of choice for service users seeking treatment in all the treatment centres included in the study. Mokwena and Morojele (2014) submit that South Africa has seen an increase in the use of Nyaope, which is commonly used among young black people in various townships. The authors posit that, the use of Nyaope in conjunction with dagga, which is also readily available and much cheaper, further contributes to the drug flooding the streets. Therefore, it can be concluded that Nyaope is overly common due to its easy accessibility and low cost.

4.4.1.4 Period of relapse following treatment

Having discovered that relapse seems unavoidable amongst black young men who are addicted to Nyaope, it was imperative to establish the period of relapse following treatment. Participants indicated that service users often relapsed within the first three to six months. For example, Participant 7 and Participant 16 agreed that it takes a minimum of three months before service users relapse following treatment.

“It depends...if someone has no one watching them most of the time...it’s a challenge, they can relapse quickly...it can take three months” (Participant 7).

“You could say three months...” (Participant 16).

Although some participants indicated that service users mostly relapse after three months, some also mentioned that it was difficult to tell as many factors come into play. Other participants highlighted that the subsidy conditions on re-application were a main barrier for service users to return as soon as they have relapsed. They indicated that if the service user did not return to seek readmission it would be hard to tell after how long they relapsed. For instance, if the service user is aware that they cannot apply for readmission before a full year lapses, they can wait to come back after that period, not necessarily meaning they relapsed at the time that they came to the facility. The following quotes illustrate some of the participants’ views regarding the implications of state subsidised treatment centres on their readmission policies.

“Because most of them are government subsidised...in fact, 90 percent of them are government subsidised, so with the government subsidy there is often a period...depending on each organisation, it can be six months to a year before one can re-apply” (Participant 20).

“You must remember, we work with a big population, so it’s hard to be specific...you know what makes it difficult is that we have subsidised beds and the guys come in and they know when they leave that if they relapse they are not allowed to come back for the next year, to even apply for a bed. So we might not even hear from them even though they relapse. So they relapse and might go to another rehab or abstain for a year or so. Sometimes we have contact with them and sometimes not. Sometimes the

guys in here when they go on a weekend pass they might also relapse, it also happens” (Participant 4).

In line with the findings of this study, Njoroge (2018) also noted that relapse following treatment may reach up to 75 percent in the first 3 to 6 months while Keen, Sathiparsad and Taylor (2015) found out that 44% of their research participants with substance use disorders actually relapsed within the first month following treatment. Afkar et al. (2017) add that individuals usually relapse within ninety days of exiting treatment. Given the above, it is clear that relapse is part and parcel of the recovery process, varying only in onset.

4.4.1.5 Effects of relapse in society

Participants were asked their views on how relapse affects society. The categories that emerged included, family instability, crime escalation, waste of fiscal resources and casting doubt on the effectiveness of SUD treatment.

a) Family instability

Substance abuse has contributed to the breakdown of families for time immemorial. Sometimes the financial and emotional burden of helping the affected individual to access treatment can be overwhelming to their significant others. Moreover, the individual who relapses after treatment may not contribute meaningfully to the development of the family. Some participants echoed the abandonment of responsibilities like providing for the family by males who continue to abuse substances even after treatment.

“Like I said, most of them are males, and most have kids, so they spend most of their time preoccupied with their habit and they do not take responsibility of their own children” (Participant 1).

“What is going to happen to the women, who is going to marry the women if most of our boys are like that? By nature, women are more than men. In our centre we can have 3000 new clients every year and when you interview these boys most of them will tell you that they last slept with a woman in 2002. This means that going forward

we won't have a society; they won't be a population. They are so many imbalances, issues of abuse and domestic violence" (Participant 3).

Family instability can come in different forms. For example, the family of an individual who has relapsed after treatment usually experience an emotional burden, where they may feel frustrated or saddened by the individual's use of substances. If the individual used to be the breadwinner, the persistent use of substances may result in job loss or careless use of money which further transfers the economic burden to other members of the family. As a result of substance abuse, the service user tends to disregard family ties and responsibilities, which often results in tensions and dissatisfaction in family relations. SUDs have long been associated with issues related to family dysfunction (Makhubele, 2013). As the individual relapses and continues to use substances, their social functioning is affected, which may further cause more problems such as high risk sexual behaviours and violence (Radebe, 2015; Amoore, 2016). Daley (2013) adds that the effects of substance abuse vary from family to family, depending on various factors which include the severity of the disorder, other co-occurring disorders and whether the family is resilient or not. The author further maintains that family instability may also be as a consequence of some sort of abuse or violence, as well as divorce or separation. As indicated by the participants, issues of domestic violence and other forms of abuse such as physical and emotional abuse also thrive when the service user persists in substance use.

b) Crime escalation

Participants indicated that one of the effects of relapse on society was that the service users re-engage in criminal activities to feed their habit.

"Crime, that's a big thing. The moment they go back on drugs they need money for it, they will rob they will steal, so it's unsafe for the population around" (Participant 4).

"Obviously when the person goes back to using, they will start stealing and vandalising again" (Participant 6).

Substance abuse is heavily linked to the burden of crime in South Africa, with 60 to 80 percent of crimes closely related to substance abuse. Moreover, substance use

motivates users to commit criminal activities which enables them to get the money needed to buy the substances (HSRC, 2007; Nduna & Jewkes, 2012). The link between illicit drugs and crime has been long established. Most violent crimes occur when the perpetrators are under the influence of substances (NIDA, 2014; Stein, Ellis, Thomas & Meintjies, 2012). It can also be added that the close relationship between crime and substance abuse is what contributes to the attitude of society towards individuals with SUDs. Some of the crimes committed under the influence of substances leave indelible marks in our society, making it hard for society to be sympathetic towards people with SUDs.

c) Waste of fiscal resources

Some participants indicated that relapse is mostly viewed as a waste of fiscal resources. For instance, participants highlighted that the service user who has relapsed, when they are readmitted at the same facility from which they were previously admitted, they actually occupy the space that was meant for someone else who deserved a first chance to be treated. In simple terms, this means that the state is paying twice for one person for the same treatment while the money could have covered two people in treatment. Participants' responses are outlined below:

"When you take these people for detox at the hospital, the nurses and the doctors say that these people are just wasting our resources, there are people who are sick..." (Participant 8).

"You are hoping that a person goes to rehab so that they can build their life afterwards, so once they relapse, to them and to the whole community it's like you wasted resources" (Participant 2).

"In terms of resources, they will be taking the space of someone else who is supposed to get the help that they already got" (Participant 15).

Swanepoel et al. (2016) agree that substance abuse and relapse have an adverse impact on society, especially in the developing countries such as South Africa. They assert that it makes huge demands on the attainment of social development goals which slows down development of society at large. For example, the resources that are used for the treatment of relapsed individuals could be channelled towards the

building of more treatment facilities. The complexity of SUDs and their co-occurrence with other mental disorders demands a more comprehensive and coordinated treatment approach, which further drains fiscal resources (Amoore, 2016; Kalula & Nyabadza, 2012). Furthermore, the State is also faced with major costs in covering problems such as unemployment, welfare dependence and criminal justice issues that arise as a result of continued substance use and relapse. Voskuil (2015) concurs that the re-admission of relapsed service users has an adverse effect on the optimal use of allocated funds as well as on the capacity for first time admissions. For instance, in 2011, the City of Cape Town in its Alcohol and Other Drug Harm Minimisation and Mitigation Strategy (CoCT AOD) 2011-2014 report, noted that they used almost four times the amount allocated per patient for a 6- week inpatient admission due to high rates of relapse (CoCT AOD, 2011). It can therefore be deduced that using money on readmissions instead of using it on new admissions compounds the problem of substance abuse treatment even further. It means that more service users that really need treatment have to wait while some people access treatment for the second or even third time due to relapse.

d) Doubts on effectiveness of treatment

The majority of participants indicated that when service users relapse following treatment, it casts a shadow of doubt on both themselves as treatment professionals and the effectiveness of treatment approaches employed in the substances field as whole. The service users' peers and the community at large start to wonder if the treatment programmes or methodologies employed really work. This could lead to many people losing faith in the whole substance abuse treatment system. Participants shared their views with regards to this:

"People are even starting to question our models if they are working or not because we have someone who has gone to rehab, from then, as early as 3 months afterwards they relapse. Boys at the township will say what is the need for me to go to rehab if so and so went to rehab and failed, why should I go there because I will be in the same predicament" (Participant 3).

"When a person relapses... it changes their attitude towards the rehabilitation process, they feel like it's useless and all that" (Participant 18).

Myers et al. (2009) concur with participants' sentiments that negative beliefs about the quality and effectiveness of treatment act as barriers to the use of existing services. The fact that treatment appears to have low success rates, with lifetime relapse rates as high as 60% does not really help the situation. Service users, treatment professionals and policy makers alike are led into thinking that substance abuse treatment does not work. Myers, Govender, Manderscheid, Williams, Johnson and Koch (2017) contend that although the South African substance abuse treatment system is well established, there have always been rising concerns about the quality of treatment which acts as a major hurdle to access of treatment services. Furthermore, the medical conditions, the increased costs and associated stress caused to the significant others and society at large make it look like a battle that has no end. As a consequence, the general consensus inclines towards the fact that treatment in SUDs is a futile exercise (Tai & Volkow, 2013; Amoore, 2016).

4.4.2 Theme 2: Factors influencing relapse in individuals with SUDs from an ecological perspective

Relapse is an unsystematic, complex and dynamic occurrence that is often determined by a wide range of factors interacting together (Gonzales, Anglin, Beattie, Ong & Glik, 2012). The factors that influence relapse as given by the research participants are presented under the different levels of the ecological perspective. The ecological perspective conceptualises the individual's environment as a set of nested structures hierarchically arranged at four levels around the individual, from the closest to the furthest. The four levels postulated are the micro-level, meso-level, exo-level and the macro-level. The majority of factors given by the participants fell under the micro-, meso- and the macro-levels, with a few falling under the exo-level. This could be due to two reasons: firstly, because the participants mostly render services to individuals (Micro-level), families (Micro-level) and the larger community which includes churches and schools (Meso-level) and secondly, because they are funded by the government and informed by national policies and legislations (Macro-level) in their rendering of services. Moreover, Bronfenbrenner (2005) and Visser (2007) postulate that the exo-system tends to be more of an extension to the meso-system, meaning that some factors may straddle between the two levels of the ecological system. These factors are discussed below under the four different levels of the ecological system.

4.4.2.1 Factors on a micro-level

The micro system includes face to face interactions between the individual and those closest to them like the family (Greene, 2008; Bronfenbrenner, 2005). From the participants' responses, factors that fell under the micro-level included poor social support, premature termination of treatment, use of ineffective coping skills, the chronic nature of SUDs, stage at which the service user seeks treatment and lack of aftercare programme attendance. These factors are discussed below.

a) Poor social support

Participants indicated that poor social support was one of the biggest contributors to relapse. They emphasised the need for support following treatment especially at the family level.

“When a person leaves here and they go back home and they have no support, it can cause relapse” (Participant 18).

“Lack of support from the family, some families are not supportive, sometimes whenever they have an argument the person is reminded of where he is coming from as an addict and because most of these people lack anger management skills, they just end up going back to using drugs” (Participant 14).

“Support is needed in any kind of illness...” (Participant 5).

Service users sometimes relapse because of the stigma they are exposed to when they go back home after treatment. Often, the family literally refuses to have anything to do with the service user, right from the beginning of the treatment process until they are discharged. Service users often relapse because they were met with resentment and hostility, which include withdrawal of financial, educational and other support structures by family members, leaving them feeling isolated and vulnerable (Appiah, et al., 2017; Afkar et al., 2016). Swanepoel et al. (2016) also pointed out that a majority of service users in their study mentioned lack of support as their reason for relapse. The authors further point out that support is not only the responsibility of the significant others in the service user's environment but also that the service user too has a

responsibility to align him/herself with other available support structures. Another participant mentioned the rejection of service users after they exited treatment:

“Some of them, when they come back from rehab, the family wants nothing to do with them, other family members even refuse to come for family sessions, they still treat the person as an addict and the individual ends up feeling like there is no point in changing since the family does not see the difference” (Participant 8).

It is evident that social support plays a key role in the treatment success of the service user. For instance, it has been found that, when the family unit is supportive and does not stigmatise the service user, the chances of lasting change outweigh those of relapse. However, Panebianco, Gallupe, Carrington and Colozzi (2016) argue that social support can sometimes actually facilitate continued drug use by providing substance purchasing advice, money to buy drugs, and creating a conducive environment for the use of substances. As such, the support given should augment the service user's efforts to remain abstinent as opposed to feeding old habits.

b) Premature termination of treatment

Participants also suggested that overestimation of treatment success is a strong precipitating factor in relapse, whereby the service user prematurely exits treatment because they feel that they can maintain sobriety on their own. They pointed out that service users usually become over confident when they no longer feel the withdrawal symptoms and assume that they can manage independent of the treatment system. Below are the participants' views concerning the effects of premature termination of treatment:

“The belief that once the withdrawal symptoms have subsided, they are ok...not understanding that this is a chronic illness that requires great commitment” (Participant 20).

“Ok, like now, you have graduated after you have undergone a programme. After you have graduated, the family is supporting you, you think it's going to be easy...you want to leave even before you have completed your treatment” (Participant 17).

“When they attend the three to four months of treatment they now feel they are ok and they don’t continue with treatment...they feel like they are ready to face the world and they go home and they relapse” (Participant 11).

Swanepoel et al. (2016) also found out that service users relapsed because they had misperceptions about their ability to control their drug use after treatment. In agreement with the participants’ views; Brorson, Arnevik, Rand-Hendriksen and Duckert (2013) note that staying in treatment has been largely associated with favourable treatment returns and most individuals relapse because they simply ‘drop out’ of treatment, meaning that they leave the treatment process before completion. More researchers concur that the longer the service user stays in treatment, the better the chance they have to retain treatment gains (Basu, Ghosh, Sarkar, Patra, Subodh, & Mattoo, 2017; Jhanjee, 2014). However, Basu et al. (2017) further argue that, the treatment approach should be matched to the treatment needs of the service user. For instance, shorter treatment interventions can be applied on service users who are more susceptible to dropping out. The authors found out that individuals with a single SUD, those who were employed and those advanced in age, were more likely to drop out of longer term treatment interventions. Consequently, premature exit from treatment does not necessarily imply staying for a longer period in treatment, it actually means completion of the treatment programme, whether long-term or short term. This means that, for service users to be able to sustain treatment gains and avoid relapse, they should adhere to the treatment programme specifically tailored according to their needs.

c) Use of ineffective coping skills

Coping is any action taken in response to a perceived stressor. Service users may relapse because they do not know how to deal with the stressors or frustrations they come across. Participants responded to how they view the use of ineffective coping skills as a contributor to relapse:

“Some people don’t know how to deal with frustrations, because in here, they have us for 8 hours, if not 24 hours, they have us as their support system, we are always here to listen but on the outside they are on their own” (Participant 18).

“They go out there and are faced with difficult situations...instead of implementing the strategies they learnt here for dealing with such situations, they take the easy way out...” (Participant 10).

“Some people start okay, but seem to lose momentum as they go...as if to lose the drive to stop using substances. Those people start to miss sessions and start to give excuses, until they completely stop treatment sometimes” (Participant 1).

“One person can come to rehab and learn everything but they go back and implement nothing. They keep the same company; you go to the same places...they simply are not motivated to make certain changes” (Participant 12).

The application of effective coping skills has always been regarded as a vital component in relapse prevention and has often been applied as part of treatment interventions (Kuper, Gallop & Greenfield, 2010). Swanepoel et al. (2016) found out that most respondents in their study relapsed because they lacked effective coping mechanisms when faced with stressful events. As indicated by this study's participant above, some service users learn coping strategies during treatment but they lack implementation when faced with an actual high risk situation. As a result, they lose motivation and feel as if they have not learnt how to deal with the high risk situations, which often leads to them feeling powerless over the situation and relapsing. Isobell et al. (2015) assert that without motivation, even in the presence of an 'ideal' environment, where funds, facilities, support are made available, there can be no progress. Njoroge (2018) adds that some clients relapse because they simply do not believe in themselves. It can therefore be concluded that crucial to the recovery process, service users should learn to actually apply the skills and strategies they learn during treatment in order to avoid relapse. They must apply the correct coping skills to the relevant situation, otherwise the coping skill loses its efficacy.

d) The chronic nature of SUDs

Some participants pointed that the nature of SUD as a chronic relapsing brain disease makes it difficult for a service user to maintain sobriety. SUD is defined as a chronic, relapsing brain disease that involves compulsive drug use despite dangerous consequences. Substances alter brain structures and functions which can sometimes

lead the individual to engage in harmful and self-destructive behaviour (APA, 2013; ASAM, 2018). Given the above, it is clear that the individual with an SUD gets to a point where they can no longer control their urge to use substances due to altered brain function. Participants' views are expressed in the following narratives:

“Seeing that addiction is a chronic brain disease, every person in South Africa that has a chronic illness in South Africa relapses, the one with sugar diabetes, one with HIV take medication to keep their head above the water...but with addiction there is a time when you have to stop using medication and you maintain sobriety on your own...so as compared to other illnesses its hard” (Participant 17).

“let’s not forget that addiction is a relapsing brain disease, so that also contributes” (Participant 10).

“The nature of substance use disorder, we need to understand that it’s a psychological disease because it affects the brain” (Participant 2).

Mutlu, Demirci, Yalcin, Kilicoglu, Topal and Karacetin (2016) also found out that treatment retention or abstinence rates tend to decrease over months following discharge from treatment which further reflects the chronic nature of SUDs. SUD is a brain disease that only goes into remission and therefore the individual should always be on high alert in order to avoid slipping back into use.

e) Stage at which service users seek treatment

Some service users relapse because they access treatment at a much advanced stage of SUD (severe SUD), which makes it difficult to maintain sobriety (APA, 2013). Dennis and Scott (2007) are of the opinion that there is a need for early diagnosis and intervention if treatment is to achieve lasting results. They add that the age of substance use initiation and the duration of use before starting treatment is directly related to the time it will take to reach abstinence. Participants shared the following ideas regarding the stage at which service users seek treatment as a precipitant of relapse:

“Some of them, by the time (they access services) they are very much advanced in the process of addiction...” (Participant 20).

“Those that come from the streets, having lost everything are the ones that struggle a lot...they have basically lived on substances and it’s not easy for them to let go (of the substances) ... they lie about everything, you cannot tell if they have really stopped or not” (Participant 8).

“Some will not come to the facility until they are compelled by law or family members and sometimes by then, it’s too late” (Participant 12).

Moeeni et al. (2016) concur with the participants’ views that the longer the service user takes to access treatment, the harder it is for treatment to be effective. Freedman (2018) notes that what further exacerbates the late entry into treatment is the fact that most service users do not willingly present themselves for treatment, they are usually coerced by one situation or another. In agreement with the findings of this study, the author notes that some service users do not voluntarily access treatment but are referred through the Justice System or family as a condition for reintegration into society. Furthermore, Van Wyk (2011) is of the view that although SUD is chronic in nature, early treatment has the potential to avert a lot of negative effects. Van Wyk (2011) maintains that most practitioners trust that providing treatment at an early stage has the potential to yield positive results before SUD as an illness becomes more severe and more challenging to treat. It can therefore be deduced that early treatment access has a positive correlation with a later onset of relapse or maintenance of sobriety for a longer period.

f) Poor attendance of aftercare programmes

Participants noted that some service users relapse because they do not attend aftercare programmes as recommended. Dennis and Scott (2007) assert that individuals with SUDS require a variety of support services and can benefit from involvement in aftercare services. Participants noted the following:

“...it’s a disease that requires constant maintenance, but they don’t attend aftercare” (Participant 20).

“...the other thing is not attending aftercare services, it does affect one” (Participant 8).

Research has proven that active aftercare intervention actually slows post treatment relapse compared to nonattendance (Burleson, Kaminer & Burke, 2012; Vanderplasschen, Colpaert & Broekaert, 2010). However, Manuel, Yuan, Herman, Svikis, Nichols, Palmer and Deren (2016) noted that only about half of the service users referred for aftercare services actually access these services, despite the fact that aftercare services have been proven to help maintain treatment gains. Moreover, there is lack of adequate monitoring to make sure that service users follow through with recommendations, resulting in relapse. Consistent with the findings of this study, Vanderplasschen et al. (2010) maintain that some service users are simply not willing to attend aftercare, while some are hindered by issues like travelling arrangements. However, the authors also note that the effectiveness of aftercare largely rests on the motivation of the service user to actually attend in the first place. In other words, the service user must be motivated to attend aftercare and also believe that they will benefit from it. Burnhams and Parry (2015) also note that aftercare services are essential as they are usually less costly and more flexible than mainstream treatment, allowing the service user to continue receiving the necessary support and care. Notwithstanding, it has been found that most clients do not continue with aftercare programmes after treatment and there is no follow-up which often leads to relapse as service users find themselves lying idle and roaming with the same substance abusing company (Keen et al., 2015; Mahlangu, 2016). South African legislation makes provision for aftercare service as a requirement for adequate treatment. It prescribes that individuals suffering from addiction should have access to professional aftercare services (RSA, 2008; Van der Westhuizen, Alpaslan & De Jager, 2013). Ramlagan et al. (2010) contend that lack of funds to continue with aftercare services and the lack of aftercare centres and services are among the reasons why service users do not attend aftercare, which consequently aggravates relapse.

4.4.2.2 Factors on a meso-level

The meso system includes the interactions between the microsystems of the individual's environment such as the school and the family (Greene, 2008; Bronfenbrenner, 2005). Factors that were mentioned on this level include stigma from society and availability of substances in the service user's immediate environment.

a) *Stigma from society*

Sometimes society stigmatises relapsed service users to a point where they are not able to fit in. There is a general underrepresentation of people seeking treatment due to various factors such as inaccessibility of treatment centres, unaffordability of treatment as well as the stigma associated with seeking treatment (Myers & Parry, 2005; Sorsdahl, Stein & Myers, 2012; Amoores, 2016). Makhubele (2013) is of the view that society has little empathy for SUD clients and views them as less deserving of treatment compared to individuals with mental or physical disorders because SUD is regarded as a self-inflicted disorder. As a result of the judgement and stigmatisation they receive from society, service users resort to not divulging the severity of their SUD, to a point that they do not seek help at all (Freedman, 2018). It can also be argued that those that relapse after receiving treatment would be faced with much more stigmatisation if they even try and access treatment once more, as a result they relapse in 'silence'. Van Wyk (2011) further posits that self-stigma is also a major impediment to successful retention of treatment gains as service users place the stigma of substance use upon themselves. In other words, they write themselves off before anyone else can judge them based on their disorder.

One participant said: *"Society is very judgemental and unforgiving...it's a sad fact that society will name and shame and not give an opportunity to a person who is saying now I'm have stopped...that's what really drags them backwards, that the society doesn't really believe that everything is ok now"* (Participant 16).

And the other said: *"The clients are willing to stop but immediately (when) they go back to their communities; they are rejected..."* (Participant 8).

The mesosystem forms a vital part of the service user's environment and as such, when they are rejected at this level, their functioning is negatively affected. Given the participants' sentiments and the literature above, it is clear that societal stigma is among the worst precipitants of relapse. Perhaps changing the attitude of the society through education on SUDs can make a huge difference.

b) Availability of substances in the service users' immediate environment

Participants also indicated that the availability of substances in the communities where the service users live makes it hard to keep sobriety. The availability of drugs in the client's neighbourhood also contribute to relapse (Meade, Towe, Watt, Lion, Myres, Skinner, Kimani & Pieterse, 2015; Nyege, Dike, Nkamare, Robinson-Bassey & Wokne-Eze, 2017). Ramlagan et al. (2010) add that clients are easily influenced in the environment, especially those in outpatient treatment, where the helping professionals have little control over them. Caprioli, Celentano, Paolone, and Badiani (2007) further postulate that the availability of substances in the service user's immediate environment serves as an encouragement for continued use of substances. Service users who have to interact with the same people in the same environment while accessing treatment are faced with the daily challenge of coming across substances as indicated by these participants:

"...also just an environment where there is a lot of drugs in the area. If there are drugs in every corner, it's very hard" (Participant 4).

"They are constantly bombarded with triggers... every day" (Participant 11).

Afkar et al. (2017) concur with the participants' views that an environment that is full of substances and friends who also encourage substance use paves way for relapse. To further expound on this finding, it can be said that although the service user has learnt ways to deal with high risk situations through treatment, they are faced with the same circumstances that first led them to substance use in the first place. They are still in the same environment, spending time with the same people. Mokwena and Morojele (2014) add that as much as communities can be effective resources for drug abuse prevention exercises, they can also propagate drug use, especially where highly addictive and cheap substances such as Nyaope are involved. The authors further maintain that underprivileged communities are the most likely to brood excessive substance use. This could be due to lack of employment opportunities and recreational facilities, leaving substance abuse and related crime activity the only ways to pass time and make sense of the realities of poverty.

4.4.2.3 Factors on an exo-level

The exosystem consists of elements that have a profound impact on the service user, even though the service user is not directly involved with them (Greene, 2008; Bronfenbrenner, 2005). Examples of the exosystem can be the treatment facility, whereby some decisions taken, like the duration of inpatient treatment, have nothing to do with the service user but affects them immensely. As will be discussed in category (a) under this subtheme, the time spent in rehabilitation has a bearing on the recovery process of the service user. Other categories included comorbidity of SUDs and mental disorders, lack of family involvement and poor quality treatment services.

a) Inadequate time spent in treatment

Among the factors influencing relapse is the length of time spent in treatment. Some participants specifically referred to some inpatient treatment programmes whereby the service user stays for only a month and a half, which is not enough given the nature of SUDs. The participants' views are expressed below:

“The way the treatment programmes are structured...the time frame of the treatment programmes is very short...currently where we refer they take six weeks is just one month and two weeks. Looking at the nature of Substance use disorder, that is not enough time, I think they end up compromising the time so that they cater for everyone” (Participant 7).

“Sometimes due to the high demand for treatment, we are forced to implement short term treatment programmes...it could be another reason for relapse” (Participant 18).

“These people need to stay in (rehabilitation facilities) longer for them to completely rehabilitate...otherwise we release them too early when they are not yet ready...” (Participant 20).

In agreement with these findings, research has found out that clients who stayed longer in treatment exhibited a significantly lower risk of relapse compared to those that stayed for shorter periods (Clark et al. 2015; Mutlu et al. 2016). Spending more time in treatment gives the service user enough time to rehabilitate and be sufficiently prepared to return into mainstream society. Njoroge (2018) supports the view by

pointing that the length of stay in the treatment facility has been observed to have a positive bearing on treatment outcomes whereby the success rate of treatment rises with the length of stay in treatment. Temmingh and Myers (2012) are of the view that South Africans in SUD treatment centres actually spend far below the minimum time of ninety days required to attain meaningful treatment gains. On the other hand, Myers, Williams, Govender, Manderscheid and Koch (2018) argue that shortening the treatment period can foster treatment completion. The argument is based on the fact that some service users may have other pressing commitments with regards to work or family. The authors suggest that in order to strike a balance between treatment completion and maintenance of treatment gains, service users can be linked to lower care services such as aftercare. Therefore, it can be further argued that the quality of treatment services is the determining factor with regards to the retention of positive treatment outcomes, rather than the length of time spent in treatment. Furthermore, Appiah et al. (2017) also found out that some issues such as shortages of medication and health workers, non-adherence to the treatment schedule and negative staff-client interactions also contribute to relapse. These could further lead to clients choosing to leave the treatment facility earlier than recommended, which culminates to premature termination of treatment as discussed under the micro level.

b) Inadequate diagnosis of comorbid disorders

Some participants were of the opinion that comorbid disorders can be an aggravating factor for relapse, especially if only SUD is identified and treated with the exclusion of other underlying disorders. Comorbid disorders are disorders that are experienced simultaneously, whereby the service user is diagnosed of one or more mental disorder as well as a substance use disorder. For example, the service user may be diagnosed with a certain mental disorder such as schizophrenia, over and above the SUD (David & Frenz, 2016; NIDA, 2018b). The factor is placed under the exosystem because the participants themselves, as the helping professionals are the ones to identify the comorbid disorders and act accordingly in terms of treatment, which affects the service user as he or she has no control over his/her own diagnosis. Individuals who seek treatment for one disorder are most likely to have a comorbid disorder and as such, it is the helping professional's responsibility to do a thorough assessment of the service user to identify such issues. Keen, et al. (2015) stress that programmes which focus

only on treating SUDs to the exclusion of other comorbid disorders inadequately meet the treatment needs of the clients, which may lead to relapse. The participants were of the opinion that underlying disorders should be identified and brought to the fore because if they are not addressed, relapse will be unavoidable:

“Some people leave rehab and you find that some of the underlying issues have not been addressed...or even identified. If they are not identified they will not be addressed, meaning that the client will seek treatment again” (Participant 20).

“If they have other mental conditions and they are only treated for substance use, they will not be successful in treatment” (Participant 15).

“The other issue is that we cannot admit a client who is also showing signs of a mental disorder, our facilities and staff are simply not trained to handle such. As a result, we end up having to refer them to the hospital first. Unfortunately, most of them do not come back afterwards” (Participant 6).

The participants' views show that, if the comorbid disorder is not identified, resulting in treatment only focusing on the SUD, this could lead to a relapse and the client seeking treatment again. Research has shown that an integrated treatment approach is beneficial for the service user, whereby comorbid disorders are treated simultaneously (Dennis & Scott, 2007; Kelly & Daley, 2013; Temmingh & Myers, 2012). Mauri, Di Pace, Reggiori, Paletta and Colasanti (2017) add that the comorbidity of other disorders such as schizophrenia with SUD often result in poor treatment outcomes and subsequent relapse. Clark et al. (2015) postulate that comorbidity often results in higher treatment costs as the service user will need specialised psychological and medical care. It can be argued that the resultant financial burden may lead to the service user quitting treatment and actually going back to substance use, especially given that most service users are out of employment by the time they access treatment.

c) Lack of family involvement in service user's treatment process

Some participants highlighted that the exclusion of families in the provision of services was also a contributing factor to relapse. Below are the participants' sentiments with regard to lack of involvement of family:

"One thing I know for sure causes relapse is, when we do the treatment processes we forget to involve their families ...the family should be involved from the beginning so that they provide the support needed" (Participant 15).

"Most families do not want anything to do with the client when he is in treatment...sometimes even when he goes back home, he is not welcome...what would you do...obviously they go back to using again" (Participant 13).

Hornberger and Smith (2011) noted that it is unfortunate that families are seen as part of the problem rather than part of the solution in SUD treatment, whereas family involvement should be an essential part of intake, treatment and recovery planning. The authors maintain that families should be furnished with the right information in order to understand the importance and gains of their involvement in the treatment process. When the family does not understand the trajectory of SUDs they are most likely not to be in a position to support the service user which leads to an imminent relapse. Consistent with the findings of this study, Menon and Kandasamy (2018) maintain that the lack of knowledge about SUDs within the family unit makes it even harder for the family to deal with the service user, as a result they avoid the affected family member which further contributes to more substance use on the part of the service user.

d) Poor quality treatment services

Participants indicated that most service users relapse due to the poor quality of services rendered at the treatment facilities. While some felt that the lack of quality service was due to the chasing of ever-increasing targets demanded by the government from subsidised treatment facilities, others pointed to the issue of 'once-off' therapy sessions as opposed to carefully planned and long-term treatment plans:

“Number 1, the quality of therapy. I just feel in the profession of social work its very rare in our coming together where we get deep into the gist of what is therapy... you have got so many social workers who cannot conduct a therapeutic session nowadays. Many people are getting into the profession because of the bursaries. Social workers who have got passion one can hardly find these days, that is number 1” (Participant 3).

“Most social workers especially those in government provide crisis intervention instead of intervention, they conduct once-off sessions instead of continuing services and checking what is the root cause of the problem” (Participant 18).

“Like I said, we are funded by the department...they don’t care about the quality of service...you do follow up for a month... and you just close the file because you are looking at the numbers...but I believe that if we take time and give our service users quality service then we won’t have things like relapse” (Participant 8).

South Africa is among many countries where there has been an outcry about the quality of SUD treatment (Meade et al. 2015). Temmingh and Myers (2012) maintain that although the government has responded positively to the outcry of the lack of resources in the substances field by allocating more money, there is still a lack of quality in the services provided, mainly due to lack of monitoring and evaluation of services rendered in the country. Moreover, Myers, Govender, Koch, Manderscheid, Johnson and Parry (2015) add that the addictions field in South Africa lacks adequate measurement tools and this has a negative bearing on the quality of substance abuse treatment. Given the participants’ views and the literature, it can be argued that a combination of various factors such as of lack of monitoring, chasing targets, lack of knowledge and lack of continuous therapeutic intervention leads to low quality services rendered, which consequently exposes the service user to relapse.

4.4.2.4 Factors on a macro-level

The macro system is the broader social context, which may include public policy, legislation and political systems (Greene, 2008; Bronfenbrenner, 2005). On this level of the ecological system, factors that were discussed include lack of adequate

inpatient treatment facilities and lack of specialised treatment knowledge among SUD treatment professionals.

a) Inadequacy of inpatient treatment facilities

Participants were asked what their views were regarding the contribution of lack of inpatient centres to relapse. They echoed the following sentiments:

“Sometimes the client is ready to go for inpatient but they have to wait in a long queue to be admitted and by then, they are suffering and they end up relapsing” (Participant 7).

“I think we just worried that there are not enough resources to cover the demands and we need more registered professional treatment centres” (Participant 4).

Voskuil (2015) found out that in the Western Cape, demand for treatment of SUDs is disproportionate to the available services which is further compounded by re-admissions of service users who relapse. This can be generalised to the rest of the country, especially in the Limpopo Province where there is only one outpatient treatment centre and one public inpatient centre serving the whole province. As an employee at the only outpatient centre in this province, the researcher and her colleagues have had to regularly refer service users to other provinces for inpatient admission, which is often a complicated, lengthy, back-and-forth process. As a result, service users go back to using substances as they complain that the waiting period is too long because they cannot just sit without medication or anything to help them counter the withdrawal symptoms. Lack of inpatient treatment centres is therefore one of the biggest contributors to relapse as there is no balance between demand for treatment and admission space. Myers et al. (2018) contend that the demand for treatment in South Africa far exceeds the available resources in terms of service providers and inpatient treatment services. The authors also found out that as a result, service users seeking readmission are not given priority like those seeking first time treatment. Van Wyk (2011) adds that the country has always struggled with allocating enough funds to increase the number of treatment facilities in several provinces where there is a high demand for SUD treatment.

b) Lack of specialised knowledge among SUD treatment professionals

When participants were asked their level of specialised SUD treatment knowledge, they reiterated that they felt that they were not adequately knowledgeable in the field where they are regarded as experts. Below are some of the participants' views:

“Again, you cannot work in probation services and expect to be an expert in the substance abuse field, it is a specialised field, and there is a specific knowledge. For one to have it means they must be exposed to that knowledge and to the people who have walked the journey. It’s not just a social problem like you are talking about child abuse, it’s a specialised knowledge” (Participant 17).

“Most of us when we come here, all we know is basic social work, you don’t know what to do exactly because you have not been trained to deal with clients who are addicted. The training here in the organisation helps but still we feel we are not fully knowledgeable” (Participant 13).

These study findings confirm that staff within SUD treatment facilities lack the requisite knowledge which impacts negatively on the clients (Makhubele, 2013; Isobell et al., 2015). In a study conducted by Bowles, Louw and Myers (2011), it was found that there is insufficient awareness and very little commitment to apply new knowledge in the substances field by the treatment professionals in the selected treatment facilities. Moreover, it was also found that as much as all participants received in-service SUD treatment training, only eight received training from external resources, while only four had a bit of SUD training at the tertiary level. It could be argued that there is very limited knowledge applied in the particular facilities where the Social Workers only received in-service training, considering that SUD treatment requires up to-date knowledge and expertise (Freedman, 2018). Myers et al. (2008) concur that lack of sufficiently trained professionals impedes their aptitude to meet the ever-increasing demand for SUD treatment. The University of Cape Town (UCT) has responded to the lack of specialised SUD training at the tertiary education level by introducing a Postgraduate Diploma in Addictions Care and a Master of Philosophy in Addictions Mental Health. The main aim is to help provide social welfare professionals with the essential skills to render evidence-based treatment services (UCT). According to Slabbert (2015), there is a lack of general training on the part of treatment personnel

which renders rehabilitative intervention initiatives redundant. Slabbert suggests that it is the ethical responsibility of the helping professional within the substance abuse treatment fraternity to stay abreast with latest information and the new developments. Moreover, even social workers in other fields such as adoption, gerontology or child welfare need some level of knowledge in the substances field as there is an established link between many social ills and substance abuse.

The next theme pertains to the prevention of relapse from the different levels of the ecological system.

4.4.3 Theme 3: Relapse prevention strategies from an ecological perspective

Under this theme, the participants voiced their views with regards to what strategies can be employed at the different levels of the ecological system to prevent relapse. It was noted that participants were not very familiar with the ecological perspective and while some chose not to respond to the question on this section of the interview guide, others showed an understanding of the micro-, meso- and macrosystem to the exclusion of the exosystem. Donald, Lazarus and Lolwana (2002) also refer to these three levels of the social context in the ecological system. This could be owing to the reason that the exosystem is an extension of the meso system, which makes it easier to refer to both these levels as one (Bronfenbrenner, 2005; Visser, 2007). The participants' views with the literature control are discussed below.

4.4.3.1 Prevention of relapse on a micro-level

The microsystem is the service user's immediate environment. Most participants indicated that one of the key strategies that can be employed at a micro-level to prevent relapse is the involvement of the family. They highlighted that if the family is empowered with knowledge on SUDs, they would be in a better position to support the service user and contribute to the prevention of relapse. Participants also emphasised that families should be empowered with SUD knowledge and be capacitated with support skills so that they can effectively help prevent relapse as shown in the narratives below:

“If we were to have success, we have to rebuild our families and families should be involved. To avoid relapse the families have to be taught about what is relapse. In a

fully functional environment we need parenting programmes where families would come maybe once a week or once in a fortnight where there would be different subjects which are focusing on relapse” (Participant 3).

“I think information... we have to empower families to understand addiction and to learn how to support the people. Most of the families come in and they don’t understand addiction and they cannot support them in a good way” (Participant 4).

“Family should support and not watch a person who is trying to maintain sobriety like a hawk...give the person the benefit of doubt...in life we all do mistakes and it’s about learning from our mistakes...” (Participant 8).

The family should be viewed and included as part of the treatment team. A high commitment by family members has been proven to be effective in preventing continued use of substances following treatment. Razali (2017) states that the family serves as a basic social unit which has a rewarding effect on the social and behavioural development of the service user. Afkar et al. (2017) adds that the family is the prime centre of education and the originator of an individual’s personality and therefore plays a key role in the inhibition of relapse. Appiah et al. (2017) concur that family members should be included in holistic interventions, whereby they are educated about the importance of support systems for individuals with SUDs. Vanderplasschen et al. (2010) add that individuals who have strong family support systems were found to be less likely to relapse. This goes to show the importance of family support in the recovery process. Although it may not always guarantee total abstinence, the preceding literature shows that family support can make a difference in the enhancement of post treatment outcomes.

4.4.3.2 Prevention of relapse on a meso-level

The mesosystem consists of the links and interactions between the microsystems in the service user’s environment (Nash et al. 2005). For instance, this can be the interaction between the service user’s family and their school or church. Some participants indicated that if society can be more accommodating and supportive of service users in the community, relapse rates could be restrained. There were also

viewpoints that the church can play a big role in relapse prevention as most people spend their time in churches nowadays. Participants voiced the following:

“The society has this thing of stigmatising these people, they reject them, there is not much support, if that can be changed I think these people will not relapse” (Participant 7).

“Church is one of the places where most people get their learning, they get support there as well, I said churches are now having rehabs, they can also provide a great way for people to understand what substance use is” (Participant 2).

Menon and Kandasamy (2018) are in agreement with the participants’ views, adding that research has shown that community based support systems enhance treatment outcomes following treatment. Some participants were of the view that there is not much that other stakeholders such as schools can do to prevent relapse. One participant pointed that the school system was already laden with its own curriculum to incorporate specialised SUD knowledge. The participant called for the inclusion of specialised SUD treatment social workers in schools to help with the problem of substance abuse and relapse:

“Schools, I think we are expecting a lot from them. I think schools need specialised social workers to be fully employed there, not just any social worker because in grade 12 how many boys are using dagga? Teachers, you cannot expect them to integrate all the substance abuse knowledge and their own work as well, I think we are asking a lot from them” (Participant 13).

It can be argued that the participant’s view is valid to a certain extent. The question would rest on who then becomes responsible for the remuneration of such Social Workers at the schools. It would seem appropriate for the Department of Social Development to be responsible in this matter as the department mandated with the social welfare of all citizens, but given the already overlaid budget, it would be difficult for the said department to shoulder an additional responsibility. It would therefore be suggested that the Department of Education and the private sector look into shouldering the responsibility as they also stand to benefit from substance free educational environments (Caulkins, Pacula, Paddock & Chiesa, 2002). A

collaborative effort would also seem as the closest thing to addressing the participant's thoughts on the matter of employing trained SUD treatment school social workers.

4.4.3.3 Prevention of relapse on a macro-level

Participants mentioned that there is a lot that can be done at the macro level to prevent relapse. While one participant pointed that there should be stringent laws in order to stifle drug trafficking activities, another emphasised collaboration among government institutions such as the Departments of Health and Social Development.

"The policing part of it...the law part of it...the criminal justice system...look at how much drugs are coming into the country" (Participant 20).

"Stakeholders should work together, substance abuse is seen as the problem of Social Development, Health is not doing anything, when we refer our client to the hospital, the doctors say they do not know what to do with them...everyone needs to be involved" (Participant 7).

While one of the participants indicated that the government was really showing interest and playing its part to ensure that there are subsidised beds in NGOs that deal with SUD treatment, another participant also argued that the government does not prioritise treatment of SUDs, let alone preventing relapse.

"The government is actually doing a lot ...they have subsidised beds in some inpatient centres, those are paid for by government so that people can access services for free" (Participant 6).

"You want me to talk about government now? Because those are political appointees and they don't have knowledge. Their focus is not on social services but on other issues. I wonder if we will have a government that worries about substance abuse" (Participant 3).

The participants' views show that although there are efforts at the macro level to combat relapse, there are still gaps that need to be covered.

4.4.4. Theme 4: Participants' perceptions on the nature of SUD treatment in South Africa

Participants discussed their perceptions on the nature of SUD treatment in South Africa. They also highlighted their views on the impact of the legislations that apply to the SUD field as whole. A majority shared that SUD treatment was not working too well and is certainly not receiving the same attention as other chronic diseases. For example, information about the nature and treatment of SUDs is not as widespread as information with regards to HIV/AIDS. One participant also noted the issue of other substances like Glue not being classified, which further confirms the lack of attention given to the field of SUDs in the country. The lack of access to services, especially to those in rural areas was also brought up by the participants as a sign that the treatment system is not functioning to its full potential. Furthermore, there were concerns regarding the application of treatment approaches developed in other countries like the United States and of lack of uniformity in the way SUD treatment is being applied in the different treatment facilities. Some of the views of the participants are outlined below:

“Not too much attention is being given to substance abuse and again this should be seen as an epidemic like HIV, because we are finding ourselves dealing with certain cases of substances that have not been classified as drugs, like glue. You have a patient that is using glue, there is not even a medication that can be prescribed...” (Participant 1).

“SUD treatment in our country is mostly Westernised my sister, imagine, all these treatment models we use, they are all from overseas. There is nothing that we have developed for ourselves” (Participant 4).

“Substance abuse treatment is not given as much attention as much as other pandemic like HIV and AIDS...there is a lot of misinformation and lack of knowledge about substance abuse treatment...more attention is needed; the treatment system is not up to scratch” (Participant 12).

“I think also the fact that everyone is doing their own thing...it makes it difficult to know what is working and what is not. I mean, when you look at TB or HIV treatment, it's the

same everywhere, but with SUDs...its neither here nor there. I think that affects effectiveness of treatment” (Participant 13).

“I think it’s lacking because most people who require services cannot access them, the government must increase the centres and help spread the knowledge about substance abuse, especially in rural areas” (Participants 14).

In accordance with the participants’ sentiments, Van Wyk (2011) affirms that SUD treatment in South Africa is tainted with a multiplicity of barriers. The author found out that most drug rehabilitation centres have a success rate of less than three percent. Participants also noted the issue of legislation and how it impacts the rendering of services for SUD treatment in the country. Some participants indicated that the legislation served as a guide in the rendering of services. They were of the opinion that the current legislation gives direction and sets parameters as to how far they can go in their interaction with service users:

“We are also guided by the ACT in our rendering of services, we reach out to communities and make communities aware of our services” (Participant 10).

“We treat our clients with dignity...our services are voluntary, you come here because you want to be here...we know our parameters in terms of the ACT” (Participant 9).

While some participants gave their views about the impact of legislation and policies that inform service delivery in the field of substances, it also emerged that some were not very familiar with them. For instance, other participants indicated that they were not familiar with the ISDM, which is supposedly one of the key directors of their service delivery.

“I have heard of the ISDM, but to be honest, I have not really studied it” (Participant 4).

“mmm, I’m not very familiar with the ISDM...I will look at it but at the moment I can’t say much on it” (Participant 12).

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 provides guiding principles for the rendering of services to individuals affected by substance

abuse. Those principles include ensuring and promoting access to information with regards to substance abuse. Furthermore, the Act provides for the non-exploitation of service users and their right to give consent to participate in any research related to their treatment and rehabilitation (RSA, 2008). While some participants indicated that the policies and legislation were actually good on paper others pointed that there was lack of implementation as noted below:

“Policies are already there but there is no enforcement. Like for example if you were to look at the criminal justice system, you have got a punitive approach and the restorative approach and most of the police are more into the punitive approach. They don’t believe in diversion; they believe in locking up the addict but what happens after they lock him up for seven days? what happens to the mind? He still goes back” (Participant 3).

“I think we have the best policies in south Africa but the challenge comes in implementation, so this is not a problem of the policies, it’s the problem with the people who are supposed to be implementing...the policies are straightforward” (Participant 1).

“The policies and legislations are good...very good, in writing but implementation is something else” (Participant 8).

Parry and Myers (2011) agree with the participants’ views as they point out that the government should actually focus on framing and employing an evidence-based drug policy that draws from other countries but adapted to our own context. The authors add that delegation and lack of accountability on the part of agencies such as the CDA, which are mandated to oversee the implementation of drug policies further cause bottlenecks in issues relating to implementation. Furthermore, they contend that developing a single policy to address the alcohol problem and the illicit drugs is further causing complications in terms of implementation. They argue that splitting the illicit drugs and alcohol policy development processes would actually ensure thoroughness in addressing the scourge of substance abuse in the country.

According to another participant, the substance abuse legislation seems to be working well thus far, but the legalisation of dagga may cause problems:

“We are talking about the substance abuse ACT? Its having a great impact now, there is nothing wrong with it now but if they legalise dagga...that’s where it will have problems...but so far so good” (Participant 18).

Related to the sentiments of Participant 18, on the 18th of September 2018, the Constitutional Court of South Africa ruled that Dagga was now decriminalised and could be used for private purposes. Parliament is meant to amend the specific legislation in order to harmonise it with the court ruling (Alfreds, 2018). As much as the news was widely received by various groups of people, organisations such as the South African Council on Alcoholism and Drug Dependence (SANCA) were not too ecstatic. SANCA, in their press release dated 19 September 2018, indicated that the day of the court ruling was a gloomy day for the country as the legalisation comes at a time when statistics already showed that the country is “crippled with the highest percentages of addiction in the world”. Among the many challenges that they felt could arise from such a decision was that, due to the fact that most dagga is bought on the streets laced with more addictive drugs like heroine, more people would be addicted and this would result in a treatment-need overload for the already ailing SUD treatment system (SANCA, 2018). This is consistent with what the participant indicated before the ruling was made.

4.4.5 Theme 5: Services for SUD treatment rendered in terms of the ISDM

Participants reflected on the services they rendered to service users in terms of the ISDM, which is the document that guides social welfare service delivery.

4.4.5.1 Levels of intervention in terms of the ISDM

The ISDM aims to help implement an inclusive, proficient and quality service delivery system which ultimately contributes to a self-reliant society. In order to achieve this goal, the ISDM postulates different levels of service delivery, namely, prevention, early intervention, statutory intervention and reconstruction and aftercare (DSD, 2006). The participants were asked at which levels of intervention they rendered services and it was noted that most participants were not familiar with the ISDM. While some outrightly stated that they were not familiar with it, for some, the lack of familiarity manifested in their responses. One participant blatantly stated that they had not read the ISDM and were not sure of the different levels of intervention:

“We only do treatment, so I’m not sure at what level, I don’t want to lie... I have to look into that, I have seen it but I haven’t read it” (Participant 1).

The researcher has noted with concern that there is not much literature on the ISDM especially with regard to its effectiveness or lack thereof in terms of implementation. Moreover, it is disquieting to note that most social workers in this study were not familiar with the ISDM, which is supposed to be the pillar of social work practice. For instance, Shokane, Makhubele, Shokane and Mabasa (2017) explored the challenges of implementing the ISDM in relation to social work supervision framework. The authors basically paraphrase the ISDM manual, without offering much detail. For purposes of this study, the levels of intervention will be explained in line with SUD treatment. Some participants shared their opinions regarding the levels at which they rendered services and their views are unpacked under the different categories:

a) Prevention

Most participants indicated that they rendered prevention services as outlined in the ISDM that prevention services should seek to strengthen and capacitate self-reliant service users (DSD, 2006). They pointed that the prevention services were aimed at curbing the possibility of risk of substance abuse, especially at schools among learners, mainly through awareness campaigns:

“We do prevention programmes at schools...we offer the adolescent programme at schools...it’s like taking the clinic to the school because we are avoiding them diverting on their way here” (Participant 16).

“We do prevention; our prevention is very much focused on schools” (Participant 18).

“There is a prevention team which mostly works in the community, they render services in schools, churches, pre-schools...” (Participant 10).

b) Statutory intervention/residential

It seems that although the ISDM does not particularly state that prevention services be rendered at schools, it is the norm among most SUD treatment professionals to render prevention services at schools. Lutchman, (2015) strongly argues that the enormity of the SUD problem in the country is a health issue that requires financially

backed treatment modalities, not advertisement campaigns aiming to raise awareness. The author seems to feel that the government is wasting time and resources in trying to prevent something that has already arrived. This further goes to confirm that there is very little, if any follow-up on services rendered in the substances field, otherwise if there was adequate monitoring and evaluation, it would be long established that the prevention campaigns are not yielding the expected results.

Participants highlighted that they mostly rendered services at this level in the form of therapy, rehabilitation and referral to inpatient facilities. The ISDM, recommends that services at this level should include removing the service user from the community and placing them in inpatient treatment if necessary, as a way of showing support (DSD, 2006). Participants stated the following:

“We are more treatment and rehabilitative...so it’s more secondary level” (Participant 6).

“We work with the guys when they come in. Its statutory intervention” (Participant 4).

“We do residential..., they come in and we conduct therapeutic sessions with them” (Participant 2).

The ISDM postulates that statutory intervention is rendered when the service user is either conflicted with the law or is no longer able to effectively function in the community (DSD, 2006). Given their statements, it can be concluded that the participants were offering services in line with the guidelines of the ISDM.

c) Reconstruction and aftercare

Reconstruction and aftercare is a lifelong service that is aimed at support services to enhance optimum functioning of the service user (DSD, 2006). The Prevention of and Treatment for Substance Abuse Act, 70 of 2008 also provides for the establishment of aftercare and reintegration of services (RSA, 2008). Participants indicated that they offered aftercare services as part of their treatment programmes:

“...aftercare as well...we have families coming in throughout the eight weeks that the client is here” (Participant 14).

“We also do aftercare services...” (Participant 18).

The participants, in offering aftercare services were actually in line with the recommendations of the Act, which is their principal legislative document. Jason, Davis and Ferrari (2007) determined that involvement in aftercare significantly reduced the probability of relapse. With regards to the rendering of services within the levels of intervention, participants did not refer to the early intervention. The researcher concludes that this is because, by definition and in terms of the target area, prevention and early intervention do not differ significantly. Both levels target individuals who may be at risk but have not yet necessarily indulged in the risky behaviour, substance use in this case (DSD, 2006). Therefore, the participants by highlighting that they rendered prevention services, in a way, they also included early intervention services.

4.4.6 Theme 6: Intervention methods for treatment of SUDs

Participants were asked which intervention methods they applied in their treatment of SUDs. Most participants were not very clear as to which methods they were using. However, the majority indicated that they applied Cognitive Behavioural Therapy (CBT), while a few spoke about the Matrix Model. Some also indicated that they used an eclectic approach, depending on the individual and their substance of choice. The psychosocial and medically assisted intervention methods in the treatment of SUDs are discussed below.

4.4.6.1 Psychosocial interventions

Psychosocial interventions are aimed at altering the service user’s substance use behaviour and other aspects like cognition and emotion, through a client-centred interaction between the helping professional and the service user (Jhanjee, 2014). The majority of participants indicated that they mostly used an eclectic approach because every client’s needs are different, which means that they had to individualise. Others emphasised that within the various approaches and therapies, CBT featured quite a lot. Only one participant from an outpatient facility referred to the Matrix Model.

*“**CBT**, is the one that we use mostly”* (Participant 20).

*“We have the **Matrix**...I mix it for teenagers and adults”* (Participant 10).

*“We incorporate many therapeutic approaches...I think we use strengths based a lot, positive psychology, **CBT**, solution focused, person centred...I can’t say, you work with the individual. Every person is different, so we need to have a profile and assessment of the individual and we cater for the specific individual’s needs” (Participant 4).*

*“We more of an **eclectic**, we include **CBT**, all these other approaches because substance abuse needs a more holistic approach because it affects more than just the service user” (Participant 2).*

The Matrix Model is an integrated outpatient programme that has seen massive growth and acceptance since its inception in the 1980s. It is an intensive outpatient programme that is widely delivered to a large number of people around the world with a proven track record. CBT on the other hand, is most widely applied in the treatment of SUDs because of its ability to help the service user address harmful thought patterns. It is a research-based treatment therapy that has been proven to be efficient in the treatment of SUDs (Rawson & McCann, 2005; Magill & Ray, 2009). It is therefore not a surprise that these two treatment models would feature prominently as the most applied, given their global recognition and proven efficacy. However, as indicated by the participants, the interventions are applied as per individual treatment needs, hence the application of an eclectic approach in most cases. An eclectic approach in the treatment of SUDs combines different intervention methods to develop a treatment plan for the benefit of the service user. The researcher also noted that participants seemed to have limited knowledge with regards to other intervention methods such as MI and 12- steps.

4.4.6.2 Medically assisted intervention methods

The use of medications to treat SUDs is known as pharmacology. While some participants indicated that they offered detox services within their facilities others indicated that they referred clients to hospitals. This could be due to limitations relating to space or lack of medical staff within the treatment facility. For instance, SANCA Limpopo as a treatment facility did not offer detox services because they did not have a Medical Doctor on site and they also lacked enough space to accommodate service users over the detoxification period. However, some treatment centres who offer

accommodation as part of their treatment, such as SANCA Horizon Clinic in Gauteng offer detox services as they have the facilities and staff. The participants shared the following sentiments:

“In the first ten days that the client is with us, they get strong medication to help them with the withdrawal, sleeping patterns, the pain that they experience...after the first ten days they are tested and then they are given a lighter dose” (Participant 6).

“We also give medication, there are nurses...the medication helps with withdrawals” (Participant 14).

“We refer to specific hospitals where we know the doctors know what to do with the client, it’s not all doctors that know what to do with a client who has substance abuse addiction” (Participant 19).

Hammond (2016) asserts that given the rate at which the scourge of SUDs is ravaging society, pharmacology is fast emerging as an effective and preferred treatment approach. One of the main aims of pharmacological agents is the management of acute withdrawal symptoms that may be experienced by the service user, through detoxification. The reduction of withdrawal symptoms through detoxification has been proven to help the service user stay abstinent, thereby curbing relapse (Douaihy, Kelly & Sullivan, 2013). Notwithstanding, Weich, Perkel, Van Zyl, Rataemane and Naidoo (2008) found out that the downside of pharmacology as a treatment approach was that the majority of medical practitioners do not have the required knowledge to effectively deal with service users who present with SUDs. Detoxification was identified as the main pharmacological approach applied within the organisations where participants are employed.

Detoxification is the first step towards the most important goal of treatment, which is relapse prevention. With the controlled and graded administration of medications, detoxification helps minimise the unpleasant withdrawal symptoms that can be experienced by the service user (Weich et al, 2008).

4.4.7 Theme 7: Recommendations for the improvement of social work services in the substance abuse field

Participants were asked what recommendations they would make towards the improvement of the substances field in South Africa. Most of them indicated that there was a training gap as well as lack of research in the field of social work, particularly in the substances field. Most participants called for the field of SUD treatment to be declared a specialised field. Some of the subthemes that emerged under this theme included that SUD treatment education be offered at the tertiary level. There were suggestions that information about SUDs should be as widely spread as that of other chronic diseases like HIV and AIDS. Some participants also highlighted the lack of treatment approaches that are developed in our own South African context. There were also recommendations for more investment in the field of substances especially towards availing more public inpatient treatment centres as well as increasing funding for NGOs that specialise in SUD treatment. Intersectoral collaboration was also highly recommended, especially between the Department of Social Development and the Department of Health to ensure smooth integration of services. Some participants also called for the linking of service users with skills development training, pointing that what mostly caused relapse was the fact that service users return to the same apathetic environment where they have no skills and can neither fend for themselves nor access employment. There were also sentiments that there should be a general acceptance of SUD as a chronic disease, as this would help change the attitude of society towards individuals with SUDs. The sub-themes that emerged in the study are presented below.

4.4.7.1 Incorporation of SUD treatment education at tertiary level

Participants indicated that the training of Social Workers in the field of substances is crucial. They suggested that it should start at the tertiary level in order to broaden the knowledge base and make sure that at least every Social Worker has basic knowledge on SUDs, regardless of what social work field they venture into. Njoroge (2018) maintains that there is a general lack in empirically supported treatments and a shortage of trained SUD professionals to deliver evidence based interventions in the field of substances. Participants explained that it would be useful if SUD training could be initiated at the tertiary education level:

“... our tertiary institutions should start incorporating substance abuse information” (Participant 3).

“Stellenbosch pays attention to substance abuse because of people there but other universities have a module, if they are lucky, on substance abuse. I think there is an educational gap, especially in our tertiary institutions” (Participant 4).

“I think it would be helpful when one is studying at tertiary, to have one module at least on substance abuse...because right now we have social workers from child welfare referring to us because they don’t have even basic knowledge on substances...instead they have to run with the client to us...” (Participant 17).

Wells, Kristman-Valente, Peavy and Jackson (2013) contend that the social work profession has a history of failing to train and prepare clinicians to work clinically with SUDs. The authors assert that studies demonstrate that social workers lack readiness in treating clients with SUDs, which emanates from a deficiency in education, training, and field placements to prepare them. Moreover, Quinn (2010) maintains that the lack of recognition, training and knowledge about SUDs in social work curricula is an institutional denial and minimisation. The author further argues that there should be a complete overhaul in social work education in order to ensure better education for future social workers and to meet the needs of a growing number of clients. Isobell et al. (2015) add that treatment professionals need to be educated about their role and be incentivised in order to improve their professional competencies.

Taking into cognisance the participants’ sentiments and the literature, the inclusion of SUD education at the tertiary level cannot be over emphasised. If every social work student is to be capacitated with basic SUD knowledge, more can be done in terms of shrinking the swelling figures of relapse in South Africa. However, there has been an improvement of late, with universities such as Stellenbosch University (SUN), University of South Africa (UNISA) and University of Cape Town (UCT) and many others now offering postgraduate courses on addictions. This is a great and necessary shift towards making sure that social workers are capacitated on the trajectory and treatment of SUDs, especially considering that they are mostly the first point of contact for individuals in need of SUD treatment.

4.4.7.2 SUD treatment should be declared a specialised field

The majority of participants echoed that SUD treatment should be declared a specialised field. Participants pointed that the reason was that, not all social workers knew what to do when faced with service users who present with SUDs, except those that are in the specific field. It was pointed that most social workers were either generic or specialised in other fields. Following are some of the views observed by the participants:

“The substances field should be a specialised field” (Participant 20).

“They need to declare it as a speciality...because now most social workers are also doing generic work and their caseload is too much” (Participant 7).

“Government...they should take fields like substance use disorder as a speciality because not everyone can do the work we do even though they are social workers, hence all social workers refer to us” (Participant 8).

Slabert (2015) agrees with the participants' views by maintaining that addressing substance abuse is a specialised field in social work. Consistent with the findings of this study, Jeewa and Kasiram (2008) also determined in their study that when participants were asked on suggestions to improve treatment at their centres, they indicated that there was need for specialist training in substances in order to boost recovery rates and lower costs related to SUD treatment. This means that, declaring the treatment of SUDs a speciality would actually have a positive impact on treatment outcomes as the treatment professionals would be adequately trained.

4.4.7.3 Access to SUDs information by service users and society at large

Participants highlighted that there is a need to make knowledge and information on SUDs commonplace like it is done with HIV and AIDS. They indicated that there is a dearth of information particularly in our communities. One of the participants emphasised that if people were made to understand the nature and chronicity of SUD as a brain disease, it would not only draw sympathy for service users but it would also increase treatment options. The following are the participants' views:

“This knowledge should be just made common. Today even if you meet a ‘hobo’ in the street, he knows what is HIV and what are the causes, how it can be prevented. I think our new crusade should be about substance abuse in that level where everyone should know, we need to redefine ourselves. Even the programmes on our television, you ask yourself what is there to learn. Our government is lost too...we see these soapies where people sell drugs as if to send a message that one can survive by selling drugs” (Participant 3).

“Exactly, so the same preventative and educational programmes need to go out to substance abuse as well. If it’s treated like any other chronic disease, it will no longer be about sympathy only but more treatment options, people will be more open about it” (Participant 4).

“There is not enough information on SUDs in the community, which is why today when a person who uses Nyaope steals in the community, and the person is well known as a drug user or a Nyaope boy, they will always be mob justice, not understanding that it’s not him, the person is under the influence of substances. You can beat him as much as you can but as soon as he recovers he will come again” (Participant 18).

Sorsdahl et al. (2012) point that the general lack of awareness with regards to where and how to access treatment for SUDs in society, which often leads to stigmatisation of individuals with SUDs can be addressed by expanding the knowledge base of our communities through spreading accurate information about the neurobiological roots of SUDs. Keen et al. (2015) found out that family members actually encouraged service users to gamble so that they could distract themselves from substance use. This is a sign that families lack knowledge and information on the nature and trajectory of SUDs, let alone how to deal with a family member who has an SUD. There is therefore a need for them to be educated about it so that they can give appropriate support to their family members. Freedman (2018) concurs by adding that awareness campaigns on SUDs should mostly focus on educating people about SUDs which would help in reducing stigma attached to individuals suffering from SUDs. Van Wyk (2011) contends that this information should not be limited to the general population but should also be shared with those that suffer the disease in order to reduce internalised stigma which also contributes to them not seeking treatment on time for fear of being labelled weak or lacking self-control. Given the above, it can be argued

that if the spread of SUD information can be as wide as has been for other chronic illnesses like HIV/AIDS, there can be positive gains in terms of SUD treatment, accessing treatment and cutting relapse rates in our society.

4.4.7.4 Application of South African based intervention methods in treatment centres

Regarding the treatment intervention methods, participants mentioned that if there is to be success, treatment approaches should be locally developed wherein people can relate. They also indicated that the manuals used should be translated into local languages which can easily be understood by the service users and their significant others:

“I advocate that we bring in more south African based theories, these are Western approaches, what is it that we as South Africans in our south African context bring” (Participant 2).

“Going through our communities, the contents of the treatment models should be interpreted using their own languages so that at the end of the day they understand” (Participant 15). The participant further stated that;

“If you can check the treatment models that we are using, they are more like Westernised, so with our African cultures it’s more like the research is not done...its lacking our context...like for in case, yesterday I was attending the SACENDU meeting, the doctors were sharing their research, but everything that they were referencing its more from overseas...”

Strebel, Shefer, Stacey, and Shabalala (2013) are in support of these views, pointing that the materials used by both service users and helping professionals should be adapted to the local context and made available in their mother tongues. Furthermore, Jeewa and Kasiram (2008) also determined that treatment programmes should be dynamic and flexible, meaning that they should be adapted to the context in which they are being applied. The participants’ views echoed the sentiments of Stein, Ellis, Thomas and Meintjes (2012) that the call for the application of evidence-based approaches for the diagnosis and treatment of SUDs has been long standing. It can be added that when the approaches applied for SUD treatment in South Africa are developed based on the evidence from our local context, they can yield long-lasting

results compared to those adapted from other contexts. This will in essence be a response to the call for decolonising the curriculum relating to theory and practice within the helping professions as observed during a symposium held between the 19 and 21st June 2019 at the University of the Witwatersrand (University of the Witwatersrand, 2019).

4.4.7.5 More investment towards SUD treatment

Participants also indicated that the government should invest more in the substances field, particularly towards SUD treatment. They indicated that the investment could go towards establishing more State funded inpatient facilities. Participants shared the following sentiments:

“Right now admitting a client who tells you they have an urgent need for rehab is ...and yet you know that once they go into the list they are probably number 59...yes we do have private rehab centres but can a person who are on drugs afford, for example, 23 000 for a month? They can’t, so we need more public rehabilitation centres” (Participant 2).

“Government has been engaging in substance abuse by opening up all these rehabs they have opened, but they are not staffed, they are not running properly. Government is paying attention in some level but the execution is a problem...” (Participant 4).

Isobell et al. (2015) observed that delays in entry to treatment have also proved to have adverse effects on the treatment process. For some service users, longer waiting periods for admission into inpatient treatment decreases motivation and increases chances of continued substance use. Most participants highlighted that the lack of public inpatient facilities in the country negatively affects treatment success rates of SUDs. They indicated that service users lose interest as they have to wait too long to be admitted into inpatient facilities, with some ultimately deciding not to seek treatment altogether. Lutchman (2015) recommended that the government should establish more State-funded treatment facilities. The author contends that the Prevention of and Treatment for Substance Abuse Act 70 of 2008 should be reviewed and amended to state that treatment facilities will be established according to the needs of the province as opposed to its current minimal obligation of establishing one treatment facility per

province. The recommendation is commendable as it was also found in this study that a great need for public inpatient facilities exists because private facilities are often costly, making them inaccessible to the average citizen. Lombard (2007) adds that what further exacerbates the lack of funds invested towards SUD treatment is the fact that the bigger chunk of the budget for social welfare services goes to social security. This has dealt a big blow to SUD treatment, especially considering that it is still at the bottom of the priority list of all social welfare services in the country.

It can be deduced from the participants' views that, although there have been efforts to tackle the problem of substance abuse, implementation is still a stumbling block. Van Wyk (2011) suggests that perhaps financing the investigation of the efficacy of brief interventions that have been proven to be effective in other countries could actually make a difference. In other words, this would involve the government engaging in some sort of a 'test-run' before they pour out a big budget on treatment approaches that may prove to be ineffective in the long-run. This would go a long way in saving the already stretched funds put aside for SUD treatment in the country.

4.4.7.6 Improved intersectoral collaboration

Participants alluded to the fact that there is need for intersectoral collaboration within the different the government departments. They mentioned that a collaboration between the different departments such as Health and Social Development would ensure that service users receive the much needed services, especially those with comorbid disorders. Participants pointed out the following:

"I remember the department of Health was once joined with social development you can never treat addiction alone by talking to the addict...there must be medical assistance...there should be serious joint working forces between the two, the health department must get involved" (Participant 9).

"We (are) in need of working together with other clinicians, we cannot do it alone..." (Participant 15).

Literature supports the participants' views that SUD treatment is more likely to be successful if tackled from a multidisciplinary and multisystem approach (Temmingh & Myers, 2012; Isobell et al., 2015). For example, service users who present with SUDs and tuberculosis as a co-occurring illness are prohibited access to inpatient treatment due to the nature of their illness. Therefore, there is a need for collaboration between healthcare practitioners and the social service providers to ensure that the service users access treatment simultaneously. Jeewa and Kasiram (2008) concur that the presence of a team of professionals will expansively address the multiple layers of addiction. Amoore (2016) posits that for treatment to be successful and manageable, an integrated approach across the medical and counselling disciplines is key. For instance, a service user who is diagnosed of a certain mental disorder cannot be contained in an SUD treatment facility but they can effectively receive SUD treatment while in a mental treatment facility. This means that all professionals required to help the particular service user can have access to the service user in a safe and befitting environment. Failures with regard to integration of services have been proven to hamper positive treatment outcomes for individuals with SUDs (Tai & Volkow, 2013).

4.4.7.7 Skills development programmes for service users

Participants echoed that service users needed to be linked with skills development resources to help empower them to be self-reliant even without formal employment. Some participants indicated that they were trying their best to link service users with skills development programmes although it does not necessarily guarantee that they will get employment after treatment:

There are many skills development programmes that we source for them, that not guaranteeing that they will maintain sobriety...We make sure they are in a skill development centre where they can develop a skill... (Participant 12).

"The thing is, when they finish treatment here, they go back home and sit...they cannot work or do anything productive. Remember most of them did not finish school and so they do not have skills" (Participant 16).

"We cannot expect much from these guys, I mean, there are no employment opportunities out there for people without a bad record as they do, so they sometimes

just give up. But I think if they can be taught a few technical skills here, or as an extension of the treatment programme, perhaps they can do something positive with their lives” (Participant 5).

The UNODC (2008) asserts that it is vital to establish links between SUD treatment with specialised social services which include vocational training and employment. The Prevention of and Treatment of Substance Abuse Act 70 of 2008 (RSA, 2008) also provides for the training of individuals with SUDs in order to assist in maintaining treatment gains and evade relapse. It is clear from the participants’ views that integration into society is the main challenge for individuals exiting treatment. When they go back to the same environment and are faced with the same hardships such as unemployment and being unemployable, it becomes much easier to slide back into substance use. But if there were to come out with skills to be able to eke out a living for themselves, to a certain extent relapse would be reduced. Perhaps if the government would also redirect social welfare funds and distribute them somewhat equally, there would be a provision for skills development in treatment facilities to give service users a head-start when they exit treatment.

4.4.7.8 More research on SUDs

It emerged from the participants’ statements that there is a gap in research within the field of substances. Increased research in the area of SUDs can contribute significantly in improving the understanding of some of the processes involved in counselling, rehabilitation and recovery. There is a need for research that will provide an overview that identifies gaps and give direction for improving treatment outcomes (Njoroge, 2018). Some of the participants were of the opinion that there is some research, but it is not adequate and also that there is lack of follow-up and publication on research findings:

“Research findings and recommendations should be published and followed up on” (Participant 5).

“is there enough information to read about substance abuse in South Africa? Not really... Yes, we do have research on this but for me I feel that it’s not enough” (Participant 2).

The study also noted that there are huge gaps in SUD research in South Africa. Most importantly, there is a paucity in research with regards to effective and evidence-based treatment approaches within the South African context. Hence, this study focused on the views of social workers as treatment professionals in order to shed light on what really contributes to the high relapse rates in SUDs. It has become clear that over and above the factors that pertain to the individuals, there is more that also needs to be attended to in terms of the approach to treatment and maintaining treatment gains following treatment. It is apparent that relapse is not only a result of the solo actions of the individual with an SUD, many stakeholders come into play; the government, the private sector, treatment professionals and society at large who unwittingly contribute to the problem. Hence, it would take a concerted effort from all the stakeholders to fill in the gaps in order to cut down on relapse.

4.5 CONCLUSION

The Chapter presented the perceptions of social workers employed in treatment centres with regards to factors influencing relapse in substance use disorders. Generally, looking at the findings, it came to the fore that relapse is a formidable challenge that is caused by a multiplicity of factors. It also became clear that most participants were lacking in the knowledge of legislations and policies that inform their work. For instance, a majority of them were not sure at what levels they were rendering services in terms of the ISDM, whereas it is one of the main policy documents that forms the backbone of service delivery in social work services. Moreover, it was also found that there was no uniformity in the treatment programmes rendered in the various treatment facilities included in the study. Among their many recommendations, participants emphasised training needs, funding for specialist SUD treatment NGOs and the need for the specialisation of the SUD treatment field.

The next chapter addresses the 5th objective of the research, namely conclusions and recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Relapse is one of the most challenging outcomes in Substance Use Disorder (SUD) treatment in South Africa. Besides wreaking havoc in families and society, it has far reaching implications in the economic development of the country at large. As was highlighted in the problem statement, huge budgets go towards substance abuse treatment each and every year, with a considerable number of service users accessing treatment services for more than once. The factors that contribute to relapse have been discussed in Chapter 2 and further empirically tested in Chapter 4. Although these factors are diverse and innumerable, it was found that there was universality between the factors noted in the literature review and those that were discovered during the empirical study conducted in Limpopo, Mpumalanga and Gauteng Provinces of South Africa. This Chapter presents the conclusions and recommendations with regards to the findings made during the empirical study. Conclusions and recommendations on the profiles of the participants are presented first, followed by conclusions and recommendations on the themes that emerged during the empirical study. Lastly, recommendations for future research outlined.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations will be made according to the themes that emerged during the empirical study.

5.2.1 Profiles of participants

The participants' age, gender, highest qualification, years of experience in the field of substances and training in SUD treatment were looked at during the empirical study. The diversity in the participants' profiles helped capture the different voices which contributed to the richness of the findings of the study.

The findings revealed that the SUD field is female dominated, which is an indication of the female dominance of the social work profession in general. It was commendable to observe that all twenty participants had received in-service training on SUDs from

their respective treatment facilities. It was also found that only a few participants attended workshops and academic courses on SUDs probably due to the financial implications of training costs. A majority of the participants were in the employ of outpatient treatment centres when compared to inpatient facilities. This is due to the fact that outpatient treatment centres generally outnumber inpatient centres in the country.

Recommendations

SUD treatment requires specialised knowledge and social workers in the field need to keep themselves abreast with new information and developments. This can be done through engaging in regular SUD training and self-development workshops and/or courses which can either be provided by the employer or as a personal effort for self-development on the part of the involved social workers.

5.2.2 Relapse in individuals with SUDs

The findings of the study revealed that relapse was high in a number of service areas within the three provinces that formed part of the study, which is consistent with literature which noted that relapse is part of the recovery process. It was also found that young Black males were more likely to relapse than females or other races and age groups. This may not necessarily be an accurate indicator of relapse rates especially with regards to gender because many females do not access treatment due to several barriers. For instance, fear of societal stigma associated with female substance use and child care needs make it difficult to determine accurate relapse rates in females.

Regarding substances that caused the most demand for treatment, Nyaope topped the list, followed by alcohol, dagga and KHAT. Due to its easy accessibility and low price, Nyaope is bound to continue to be the drug of choice for most service users who are usually unemployed. The study also revealed that it takes around three months for a service user to relapse, although it is sometimes hard to tell because some service users do not seek re-admission immediately after relapse. Within the first three months following treatment, it can be hard for the service user to maintain sobriety as they learn to re-adjust to the environment without the use of substances. Such relapse has negative effects in society which ranges from family instability, crime escalation,

waste of fiscal resources, to the fact that when service users relapse, it casts doubt on the effectiveness of treatment. It is not surprising that the effects of relapse are far reaching beyond the affected individual. It is obvious that life for and around the service user will not remain the same following treatment.

Recommendations

In light of the above conclusions, several recommendations are made.

- It was found that young Black males are most prone to relapse. The government should invest in establishing more skills development programmes or facilities for the youth, especially Black males. This would assist them by occupying their time positively as opposed to spending time seeking substances. Skills development programmes could include teaching them technical skills like boiler making for instance. Moreover, more effort should be put in to educating society on the dire effects of SUDs and the need for female service users to access services just as their male counterparts. This would assist in reducing the stigma associated with females seeking treatment. In addition, treatment facilities which accommodate females should also be established as it was found out during the empirical study that most treatment centres admitted male service users only.
- In order to cap substances that cause the most demand for treatment, there should be more stringent laws on individuals found to be in possession of or selling illicit drugs or substances in the streets. The minimum penalty of five years' imprisonment for possession of or dealing in illegal substances should be increased as this would help deter those individuals and contribute in the reduction of the amount of substances available in our communities.
- The remedy for maintaining treatment gains for longer rests on a number of factors. These include allowing service users enough time in treatment, applying evidence-based treatment approaches as well as having treatment professionals that are specially trained to render quality SUD treatment services. All these factors working together in harmony could actually improve the quality of life of service users as well as the time spent in sobriety.

- Relapse has been found to have adverse effects on society at large. A combination of educating society on the chronicity of SUDs and the application of effective treatment approaches can play a big role in diminishing the effects of relapse in society. When society understands how they can support the service users and when the service users have been effectively rehabilitated, treatment gains can be maintained, resulting in reduced cases of relapse.

5.2.3 Factors influencing relapse in individuals with SUDs from an ecological perspective

The factors influencing relapse in individuals with SUDs were sub-divided into the different levels of the ecological system; the micro-level, the meso-level, the exo-level and the macro-level.

Many factors fell into the micro-level of the ecological system. Poor social support was one of the biggest contributors to relapse in SUDs. The use of ineffective coping skills was also mentioned. Some service users were said to relapse because they prematurely terminate their treatment programme under the false confidence that they have fully recovered. The chronic nature of SUDs was also mentioned as a precipitating factor, making it difficult for service users to maintain sobriety. Moreover, the stage at which service users seek treatment was also found to influence relapse because when service users seek treatment at a much advanced stage of SUDs, it becomes difficult for them to maintain sobriety. Moreover, poor attendance of aftercare programme was also found to be a contributing factor to relapse. It can be concluded that over and above what the significant others in the client's environment can do to help them maintain sobriety, the client also has a responsibility to make a deliberate effort to make sure that they succeed. For instance, applying effective coping skills as learnt through the treatment process and attending aftercare are some of the responsibilities that are linked to the personal effort of the affected individual.

Factors that mostly influenced relapse on a meso-level are stigma from society and the availability of substances in the service user's immediate environment. When service users are stigmatised, they lose a sense of 'fit' in the community and when substances are easily accessible, they fall back into the same pattern of use, losing the gains of treatment. On the exo-level, factors included inadequate time spent in

treatment, inadequate diagnosis of comorbid disorders, lack of family involvement in service user's treatment and poor quality treatment services. The lack of specialised knowledge among treatment professionals in the field of substances can sometimes affect the quality of treatment rendered to service users, resulting in poor quality treatment services. On the other hand, the exclusion of family in the treatment process can also be an aggravating factor, as the family is left clueless on how to assist or support the affected individual. Comorbid disorders make it difficult to maintain treatment gains, especially if only the SUD has been addressed to the exclusion of the comorbid disorder. Moreover, the time spent in treatment has a bearing on the effectiveness of the treatment. Depending on several factors such as the severity of the SUD and the substance of choice, some service users may need to stay in treatment longer than others. On a macro-level, inadequacy of inpatient treatment facilities, particularly inpatient centres, was among the leading contributors to the relapse of service users. Sometimes when service users have to wait in long queues to gain admission into the limited number of inpatient treatment centres, they eventually give up on the whole idea of getting treatment and living a life of sobriety.

Recommendations are presented in accordance with the levels of the ecological perspective

Recommendations on a micro-level

- The treatment programmes offered at the treatment facilities should include the service users' family from the beginning to the end, this would help them to gain optimal understanding on the nature of SUDs and the importance of their support to the service user. This could be fostered by helping them to understand that the treatment success not only benefits the service user, but also the family unit as a whole.
- Life skills programmes should form most part of the service user's treatment programme in order to foster their assertiveness and coping skills. For instance, some participants indicated that they include teaching technical skills such as Wood Work as part of their treatment programme to give the service users' a chance to be employable once they exit treatment. This could be made possible by allocating funds specifically for skills training at the end of each treatment

programme. The funds could form part of the subsidy allocated to specific treatment centres by the government or could specifically be allocated to the various treatment centres either through private or public funding. The treatment centres themselves can lobby for donations from other charitable organisations such as the National Lottery.

- Information about SUDs and SUD treatment should be disseminated as much as possible in order for society to gain knowledge and understanding of the nature of SUDs. For starters, the audio-visual media would make an impact as most people have access to either the radio or television or both. With knowledge and understanding, family members will be well-equipped to give the much needed support to service users with SUDs. Public broadcasters such as the South African Broadcasting Corporation (SABC) can run such campaigns in collaboration with other government departments such as Social Development. Current SUD information dissemination is in the form of campaigns, mostly in schools, leading to the conclusion that there is still a huge number of people that does not have access to SUD information, especially those outside the school system.
- Service users should be encouraged to attend aftercare programmes consistently. Family members may take the lead role in doing this by offering the necessary financial and/or emotional support. The treatment professionals may also encourage service users to attend aftercare by keeping contact and making follow-ups with the service users after treatment.

Recommendations on a meso-level

- Society should be well informed about the nature and trajectory of SUDs so that they refrain from stigmatising service users who have received treatment and are in the recovery process. To see this through, the government, through Local Drug Addiction Committees (LDACs), may disseminate information on SUDs to various communities.

- A culture of a drug and substance- free society should be cultivated in order to help eradicate substances from communities. This can be done through collaborative work between community members and law enforcement. If the community members can report those who sell substances in their communities and the law enforcement in turn responds by arresting the perpetrators, the availability of substances in communities can be reduced.

Recommendations on an exo-level

- Social workers in the field of substances should be trained regularly on new developments and trends about SUDs in order to help improve the quality of services rendered to service users. Training of social workers involved in the treatment of SUDs should actually start at the tertiary level. As they enter the field and start rendering services, the government can then provide finances for regular trainings on the latest evidence-based treatment approaches. Treatment facilities should also embark on regular in-training for their staff to keep abreast with the latest developments in the SUD field as a whole.
- It is also recommended that the minimum time spent in inpatient centres be reviewed uniformly across the board, to bridge the differences between time spent in public inpatient facilities and private inpatient facilities. The budget set aside for SUD treatment could also include subsidising private treatment centres so that they can cater for service users in their care without charging exorbitant amounts. The length of time should be determined by the needs of the service user with respect to their rehabilitation process and not the availability of funds or lack thereof.

Recommendations on a macro-level

- Government should invest more in the establishment of public inpatient facilities. The minimum obligation set out in the Prevention of and Treatment for Substance Abuse Act 70 of 2008, should be amended. Instead of having at least one treatment centre per province, the Act should provide that as many public treatment centres can be established in any province, in line with the needs and demands for treatment in the said province. As a result, service users will have timely access to inpatient treatment, which will in turn impact

positively in their treatment process. Although it may be unrealistic for government to cough out more funds towards SUD treatment, given the current economic meltdown, encouraging collaboration between the Departments of Health and Social Development, could actually help. For instance, instead of building a whole new SUD treatment facility, a few beds in the hospital can be set aside for inpatient treatment for service users with SUDs.

5.2.4 Relapse prevention strategies from an ecological perspective

The findings show that if the family is involved in the treatment process by accessing information regarding the nature of SUDs and support the needs of service users, it would go a long way in the prevention or reduction of relapse rates. Moreover, the church could also play an important role for those that are spiritually inclined. This can be done by encouraging churches to include information on some aspects of SUDs in their sermons. A positive and accommodating attitude towards service users from communities was also mentioned as a way to curb relapse. Service users who are not spiritually inclined may also form support groups within their communities with other individuals in the same path.

Collaboration among government departments, especially Health and Social Development is key in the prevention of relapse. It will lead to the much needed integrated service delivery which is presently lacking. Laws with regards to possession and selling of illicit drugs in the community should also be tightened. The minimum sentence of five years should be increased to help deter those that have not yet entered the field of dealing in illicit substances. Given the findings above, it can therefore be concluded that, every part of society has a role in the prevention of relapse. If everyone played their part effectively, there would be visible results with regard to the reduction of relapse in our society.

Recommendations on a micro-level

- The family should be involved as much as possible in treatment programmes. There should be programmes specifically designed to educate and equip families of service users on SUDs, during and after treatment of the service user. This could be done at treatment centre level, whereby the SUD treatment

centres develop or adopt treatment programmes that include family members of service users.

Recommendations on a meso-level

- Social workers in the field of substances can organise workshops and trainings for church leaders in order to capacitate them with SUD information and ways in which they can assist.
- Communities need to be sensitised to allow service users to reintegrate and function normally in society. This can be done by social workers in the employ of treatment centres or as a programme funded by the government or private sector.

Recommendations on macro-level

- Statistics on drug related arrests and incarcerations should be largely publicised so that community members are encouraged to report more illicit drug dealings that they observe. Audio-visual media can be a great place to start with publications as most people have access to the radio, television or both.
- Government should ensure departmental collaboration with regards to SUD treatment through enforcement of the NDMP. This can be done by establishing independent agencies per province that not only oversee the collaborative efforts but also monitor and evaluate their efficacy. Furthermore, the agencies should report to a central authority on a national level, where feedback is given and the necessary changes or improvements are made.
- There should be a smooth flow of access to services from one department to another. For example, service users with comorbid disorders should be able to access treatment in a public health facility or a specialised SUD treatment centre with a full-fledged multidisciplinary team. This can be made possible by ensuring that there is a healthy working relationship between the Departments of Health and Social Development.

5.2.5 Perceptions of the nature of SUD treatment in South Africa

The study found out that SUD treatment was not given the necessary attention that it deserves, especially given the nature with which it is wreaking communities. Service users in the remote areas were still cut-off from accessing services compared to those in the urban areas. It was also found that the legislation was one of the best in the world and actually served as a guide in the participants' day to day operations. However, it was also found that most recommendations provided for in the legislations and policies were not being fully implemented. There seems to be a well-articulated plan but there is no execution or follow-up to check on what is practised. It can be said that implementation, monitoring and evaluation are the key aspects that are missing to the delivery of an efficient treatment system in the country.

Recommendations

- Campaigns to raise awareness about SUDs, their effects and treatment options should be intensified all over the country to make sure that knowledge and information on SUDs becomes commonplace to all members of society. All stakeholders, especially treatment facilities should make sure that statistics on treatment are well publicised for the public to be in the know. SACENDU is already making public the treatment access statistics but there are no specific statistics on people that actually exit treatment and those that are attending aftercare. For treatment facilities that offer skills training, there should be statistics as to how many people received training as well as how many of those are self-employed or employed elsewhere. This would paint a clear picture that as much as relapse rates are high in the country, there are also success stories.
- Government should also ensure that access to treatment in rural areas is also made possible. This could be done by increasing funds to specialist NGO treatment centres so that they can afford to render services beyond the urban peripheries. The funds would go towards transportation of the treatment professionals and accommodation as well as office space.
- The drawing up of policies should also include people at the grassroots level, which includes social workers that deal with service users on a day to day basis.

Although it is already happening, to a certain extent, there should be reciprocal information sharing, whereby the social workers as frontline workers give feedback on the effectiveness of services while the government makes the necessary amendments to improve where there are gaps.

- There should also be effective monitoring and evaluation tools to make sure that there is implementation of policy on the ground. This could be done at the provincial level and escalated to the national level through funding of independent monitoring agencies by the government.

5.2.6 Services rendered in terms of the ISDM

The study found out that participants rendered SUD treatment services at all levels according to the ISDM. However, their lack of articulation as to the specific levels under which their services fell led to the conclusion that there was a general lack of familiarity with the ISDM. It was found that prevention services were rendered in the form of awareness campaigns, especially at schools and in the community. These are the environments within which social workers normally operate. This could be due to the fact that the school and the community encompass the wider society in the sense that young people usually spend most of their time in the school environment and the rest of the people form the general community environment. It was also found that residential services were offered to service users with the need for treatment through a referral system from outpatient to inpatient treatment facilities. While reintegration and aftercare services were made available, participants highlighted that some service users simply did not attend the aftercare programmes and that some families were not interested in attending programmes with service users as recommended by the social workers. It can be concluded that the reason why most families distance themselves from the service user's treatment process is the emotional scars and indelible mistakes that the service user would have dealt on the family as a whole before accessing treatment. As a result, the service user feels dejected and unmotivated to attend aftercare.

Recommendations

- Once-off awareness campaigns in schools and communities have proved to have very little, if any effect, with regards to raising awareness about substance abuse. In order to improve prevention services, there should be a continuous process with follow-up sessions and ways of measuring its impact on the intended audience. Volunteers trained through specialist treatment centres can be utilised to offer these services. For instance, SANCA Limpopo has embarked on the ‘adopt a school campaign”, whereby, throughout the year, they make follow-up presentations in a particular school on substances, their effects and ways to access treatment. These campaigns aim to allow for continued and consistent intervention which actually bears fruit.
- Under statutory intervention, outpatient facilities should also offer inpatient services to avoid service users having to be referred from one facility to another as this leads to many service users abandoning treatment. This could be made possible by increasing the budget allocated towards treatment of SUDs. Government could increase the number of public inpatient facilities in the country or subsidise private inpatient treatment centres to allow for an increased number of admissions.
- In order to promote reintegration and aftercare, aftercare programmes should be service user oriented and designed in such a way that service users find it beneficial to attend. For instance, it should be combined with skills development so that service users find it worthwhile. The government and the private sector can make provision for finances specifically for skills training such as Wood Work and boiler making in facilities that offer aftercare services. Treatment facilities can also, through their fundraising committees, allocate funds for skills training.

5.2.7 Intervention methods for treatment of SUDs

It was found that most participants applied the CBT, Matrix Model and Eclectic approach in their treatment of SUDs. It was also noted that there was no uniformity in

their programmes, even in the same treatment facility in some instances. Lack of uniformity in the treatment approaches applied to the treatment of SUDs in the country seems to stem from the deficiency of evidence-based treatment methodologies that are developed and tested locally. Furthermore, this also seems to proliferate to individual treatment centres as it was noted that even in some treatment facilities, different social workers applied different approaches to treatment.

Most participants indicated that they offered medications for management of acute withdrawals in their treatment facilities. However, some indicated that they usually referred service users to local hospitals for detoxification. With regard to referrals, participants indicated that there were a lot of challenges, including that some medical practitioners did not know what to do, sometimes service users having to wait for an available bed for days or weeks, resulting in them being demotivated and giving up on the whole idea of treatment altogether. It can be concluded that although medically assisted treatments are gaining momentum in the country's SUD treatment system, there are still stumbling blocks, mostly resulting from lack of resources and lack of collaboration between the Department of Social Development and the Department of Health.

Recommendations regarding psychosocial interventions

There is a need for uniformity or at least basic treatment modalities across treatment centres. This would allow for the development and implementation of research-based treatment methods that are suited to the local context. Uniformity also makes it easy to determine what really works and what does not. The government and private treatment centres need to invest in evidence-based treatment approaches to ensure efficacy in treatment services.

Recommendation for medical interventions

- Health practitioners in public healthcare centres should be trained on detoxification of service users with SUDS. It would also be helpful that every treatment centre offers detoxification services on site, regardless of its being an inpatient or outpatient facility. The training of health practitioners can be funded

or subsidised by the government or their specific practice boards such as the Health Professions Council of South Africa (HPCSA).

- The government should also invest in establishing stand-alone detoxification centres, which will help relieve pressure for space in the already over-crowded healthcare centres.

5.3 RECOMMENDATIONS FOR FUTURE RESEARCH

Considering the results from the empirical study with regards to the factors influencing relapse in SUDS, it is recommended that future studies look at improvements that can be made in the treatment methods used in South Africa to prevent relapse. Such research would be beneficial in directing the development and refinement of South African based treatment modalities, best suited for the South African context. For instance, research in the direction of evidence-based treatment approach that is developed and tested in South Africa would help in the field of SUD treatment which has so far largely relied on approaches developed and tested overseas, especially the United States of America.

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ANNEXURES

ANNEXURE A: PERMISSION LETTER TO CONDUCT RESEARCH THROUGH TREATMENT CENTRES

Researcher: Nobuhle Ndou
Telephone Numbers: 083 374 7341(personal)
015 295 3700 (Work)
Email address: Nobbs00@gmail.com

Date: _____

Attention: _____

I, Nobuhle Ndou, the undersigned, am a Social Worker at SANCA Limpopo and also a master's degree student at the Department of Social Work at the University of Stellenbosch. In fulfilment of the partial requirements for the master's degree, I have to undertake a research project and have subsequently chosen the following research topic: *Factors influencing relapse in individuals with Substance Use Disorders: Views of social workers employed in treatment centres*. The goal of the study is to determine the causes of relapse among clients with substance use disorders from the standpoints of the Social Workers who render services to them. The research project originated from my observation, as a Social Worker in the substances field, that many of the admissions in both outpatient and inpatient treatment centres are not first time admissions. There is a prevalence for relapse among clients with substance use disorders regardless of what substances they are using. The information gathered from the research can be used to formulate and augment relapse prevention and aftercare programmes best suited for the South African Context.

I therefore request for permission from your treatment centre to conduct the research with the Social Workers in your employ. It would be important to hear what their views

are with regards to the prevalence of relapse among clients with substance use disorders. The decision to participate in the research project is voluntary.

There are no risks or benefits involved in participating in the research project. All personal information pertaining to the study will be kept confidential. Neither the participants' names nor the treatment centres' names will appear on the questionnaires or transcribed interviews. The proposed dates for the undertaking of the interviews is during May and June 2018. The actual dates will be confirmed with you well in advance.

For any questions or concerns about the study, feel free to contact me on: 083 374 7341 or at Nobbs00@gmail.com.

If you are willing to allow your Social Workers to participate in the study, please sign the form below. I would also ask for your assistance in introducing me to your Social Workers in view of participation in the study.

I, Adèl Grobbelaar, as Complex Manager of Wedge Gardens Treatment Centre having fully been informed as to the nature of the study, give my permission for the study to be conducted. I reserve the right to withdraw this permission at any given time.

Signature.....

Date.....26/3/2018.....

Stamp: WEDGE GARDENS
REHABILITATION CENTRE
PRIVATE BAG X 03
LYNDHURST
2106

I, Marina Erasmus, as [role or title] Director of [Treatment Centre name] SANCA Lowveld having fully been informed as to the nature of the study, give my permission for the study to be conducted. I reserve the right to withdraw this permission at any given time.

Signature.....

Date.....9/4/18

Stamp:

SANCA LOWVELD ALCOHOL
& DRUG HELP CENTRE
PO BOX 1073
NELSPRUIT 1200
TEL: 013 752 4376

I, Amanda Swart, as [role or title] Director of [Treatment Centre name] SANCA Limpopo Alcohol and Drug Centre having fully been informed as to the nature of the study, give my permission for the study to be conducted. I reserve the right to withdraw this permission at any given time.

Signature.....

Date.....10/04/2018

Stamp:

SANCA LIMPOPO
ALKOHOL EN DWELM SENTRUM
ALCOHOL AND DRUG CENTRE
33 KERK ST./Str. 33
☒ 1147
POLOKWANE 0700
☒ 015 295 3700

I Ndlovuho Eric Khalishu, as [role or
title Director] of [Treatment Centre
name SANCA EASTERN GAUTENG] having fully been
informed as to the nature of the study, give my permission for the study to be
conducted. I reserve the right to withdraw this permission at any given time.

Signature 

Date 29/05/2018

Stamp:



ANNEXURE B: CONSENT FORM FOR PARTICIPANTS

Factors that influence relapse in substance use disorders: Views of social workers employed in treatment centres

You are requested to participate in a research study conducted by Nobuhle Ndou, a master's student from the Social Work Department at the University of Stellenbosch. The results of this study will become part of a research report. You were selected as a possible participant in this study because you are a social worker who renders services to service users with substance use disorders.

1. PURPOSE OF THE STUDY

The aim of the research is to develop an in-depth understanding of the views of social workers employed at treatment centres on the factors that influence relapse in substance use disorders.

2. PROCEDURES

If you volunteer to participate in this study, you will be asked to do the following:

- Be available to conduct an interview at a time and place as mutually agreed to by you and the researcher, Miss N Ndou.

3. POTENTIAL RISKS AND DISCOMFORTS

No harm is foreseen during or after the research study as all interviews will be conducted confidentially without your name or identity appearing anywhere in the research narrative. However, any uncertainties on any of the aspects of the interview schedule you may experience during the interview can be discussed and clarified at any time.

4. POTENTIAL BENEFITS TO SUBJECT AND/OR TO SOCIETY

The results of this study will be on the public domain and will be of assistance to other organisations on the views of social workers on the factors that influence relapse in substance use disorders.

5. PAYMENT FOR PARTICIPATION

No payment in any form will be expected from you as a participant in the study and you will not be paid for your participation in the study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you or your organisation will remain confidential and will be discussed only with your permission or as required by law. Confidentiality will be maintained by means of coding the interview transcripts. All data will be managed, analysed and processed by the researcher and it will be kept in a locked cabinet at the researcher's place of residence.

7. PARTICIPATION AND WITHDRAWAL

You may choose whether to participate in the study or not. If you volunteer to participate, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so, for instance, if you influence other participants in one way or the other.

8. IDENTIFICATION OF STUDENT-RESEARCHER

Any correspondence with regards to the research can be directed to the researcher:

Miss N Ndou

Tel: 0833747341

Email: Nobbs00@gmail.com

Any questions or concerns about the research can be directed to the supervisor:

Mrs P Khosa, Department of Social Work, University of Stellenbosch.

Tel: 021-808 2072

Email: priscalia@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECT

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research. If you have questions regarding your rights as a research subject, contact Ms. Maléne Fouché (mfouché@sun.ac.za; 021 808 4622) at the Division for Research Development.

SIGNATURE OF PARTICIPANT

The information above was described to me, -----
(the participant), by Nobuhle Ndou, (the researcher) in English, a language that I am fully in command of. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ (name of participant). (He/She) was encouraged and given plenty of time to ask me any questions. This conversation was conducted in English and no translator was used. _____

Signature of Investigator

ANNEXURE C: SEMI-STRUCTURED INTERVIEW GUIDE**Factors influencing relapse in individuals with substance use disorders: Views of social workers employed in treatment centres****NOBUHLE NDOU****Please be advised:**

- All the information recorded in this interview will be regarded as confidential.
- The name of the organisation and your name will be kept confidential.

Instructions:

- Please be as honest as possible in your responses to the questions.
- You may choose not to answer any of the questions.

Date of interview	Participant code
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1. PROFILE OF PARTICIPANT

Gender	Age	Race
--------	-----	------

1.1 Qualifications**1.1.1 What kind of social work qualification do you have?****1.2 Is your organisation an inpatient or outpatient facility?****1.3 How long have you been rendering services in the field of substances?****1.4 Tell me about the kind of training you received in the substances field.**

1.5 How often do you have training per year in your organisation?

2. THE NATURE AND SCOPE OF SERVICES RENDERED

2.1 Describe the nature and scope of social work services rendered in the organisation in terms of the levels of intervention as outlined in the Integrated Service Delivery Model (ISDM, 2006).

2.2 In your opinion, are the programmes you use in the treatment of substance use disorders effective? Motivate your answer.

2.3 What are your views on the nature of substance abuse treatment in South Africa from a social work perspective?

2.4 According to your experience, which is the substance that mostly lead to relapse? Motivate why?

2.5 What is the gender of service users who mostly seek treatment at your organisation?

2.7 What are the age groups of those service users?

2.7 Which service users do you often render services to in terms of racial groups?

3. RELAPSE INFORMATION

3.1 How long after treatment do the service users relapse or seek readmission?

3.2 How many times, based on your experience, do service users seek readmission?

3.3 In your opinion, what are the factors influencing relapse in SUDs?

4. TRAINING

4.1 As a social worker in the substances field, do you feel you are adequately trained to render the best service?

4.1.1 Based on your response above, do you feel there is a need for more training for social workers in the substances field, if so, what should the training look like?

5. RECOMMENDATIONS

5.1 What recommendations would you make towards improving social work services in the substances field?

5.2 In your opinion as a social worker, what do you think could be done at different levels of society to prevent relapse to SUDs from an ecological perspective?

5.3 Would you like to add anything not discussed in the interview?

Thank you for your participation in the study

ANNEXURE D: REC NOTICE OF APPROVAL



UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC Humanities New
Application Form

2

October

2018

Project
number:
7665

Project Title: Factors that influence relapse in individuals with substance use disorders: Views of social workers employed in treatment centres

Dear Miss NOBUHLE NDOU

Your REC Humanities New Application Form submitted on **26 June 2018** was reviewed and approved by the

REC: Humanities. Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
13 July 2018	12 July 2021

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (**7665**) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Research Protocol/Proposal	Ndou Final Proposal	26/06/2018	
Informed Consent Form	NDOU INFORMED CONSENT	26/06/2018	
Data collection tool	NDOU THEMES FOR INTERVIEWS	26/06/2018	
Proof of permission	Permission letter SANCA LOWVELD	26/06/2018	

If you have any questions or need further help, please contact the REC

office at cgraham@sun.ac.za. Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.

The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research: Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrolment. You may not recruit or enrol participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrolment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the REC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC.

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrolment, interactions or interventions) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.